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ABSTRACT

A study examined structures, processes, and practices of assessing competence in nursing and midwifery education programs in Britain. The methodology included documentation, interviews, and observations. Most interviewees were clear about the shortcomings of traditional assessment. In a satisfactory partnership, all the partners made a significant contribution to the design of the assessment strategies and documents and felt a sense of ownership. Continuous dialogue was essential. Increasing the number of independent witnesses and increasing the evidence base were proposed to overcome inadequacies of the widely used checklist assessment format. The following contextual issues were raised by interviewees with regard to practice placement: liaison and continuity of support, course constraints, workplace demands, and individual commitment. Principles required for effective monitoring and development included the following: involvement of all relevant groups, appropriate support, putting discussion about assessment on the agenda, action based on discussion, and development on the national level. Dialogue was found to be a mechanism for combining learning and assessment in which theory was examined in the light of practice and practice in the light of theory. Recommendations were made for action to develop the assessment of competence in nursing and midwifery education. (Appendixes contain 18 references, 160-item bibliography, and a list of survey methods.) (YLB)

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RESEARCHING PROFESSIONAL EDUCATION

Education, Dialogue and Assessment: creating partnership for improving practice

English National Board for Nursing, Midwifery and Health Visiting

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RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

Education, Dialogue and Assessment: creating partnership for improving practice

Terry Phillips
Helen Bedford
Jill Robinson
John Schostak

A report based on
Assessing Competencies in Nursing and Midwifery Education
(the ACE Report)

London, 1994

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Participating institutions

Staff and students in the following approved institutions and their associated practice placement areas took part in the research:

Bede College of Nursing and Midwifery

Leeds College of Health

Newcastle and Northumbria College of Health Studies

The Norfolk College of Nursing and Midwifery

North Yorkshire College of Health Studies
(formerly Harrogate and Northallerton College of Nursing Studies)

Riverside College of Health Studies

Romford College of Nursing, Midwifery and Health Studies
(now Redwood College of Health)

The Suffolk and Great Yarmouth College of Nursing and Midwifery

The University of Greenwich, Faculty of Health
(formerly Thames College of Health Care Studies)

The Project Team would like to extend very grateful thanks for their participation and enthusiasm throughout the lifetime of the project.

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Explanatory notes

The findings and recommendations contained within this Report relate to issues in the assessment of competence across the range of nursing courses (all branches in the case of pre-registration diploma of higher education) and midwifery courses which formed the focus of this study. Findings or recommendations which relate specifically to either midwifery, nursing or a particular branch of nursing, are noted as such.

Approved institution: this term is used throughout according to the Board's definition (ENB, 1993):

'An educational institution which is approved as having met the Board's requirements for the conduct of courses for nurses, midwives and/or health visitors.'

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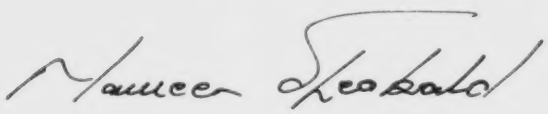
Foreword

The English National Board is pleased to publish this report as the first in its new series 'Researching Professional Education'.

The purpose of this new series is to make the results and implications of research commissioned by the Board readily available to the key stakeholders: to policy makers, managers, practitioners, researchers and educators. The Board intends to enable these groups to have ready access to important research findings from which to plan and implement developments in nursing, midwifery and health visiting education.

The Board's research programme is planned to ensure that education for practice is relevant both professionally and academically. Research based evidence provides an important dimension for the development of policy.

The Board has accepted this report and is undertaking work, based on the findings and recommendations, to develop its educational policy in relation to assessment. The Board hopes that educators, managers, practitioners, researchers and policy makers will work together in partnership to improve practice.



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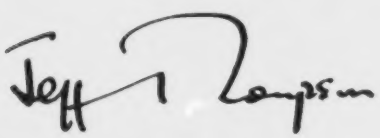
Chair, English National Board



Jeff Thompson

Chair, Research and Development Group, English National Board

London, 1994

Contents

1.	**The background to the report**	**6**
1.1	Introduction	6
1.2	To whom does the research report have something to say?	6
1.3	Professional competence and subjective assessment	7
1.4	Educative assessment	8
1.5	The setting up and operation of the research	11
2.	**The assessment of competence**	**13**
2.1	What is competence?	13
2.2	Assessment as supportive critique	16
2.3	The development of competence	17
2.4	The purpose of assessment	18
2.5	The persistence of the familiar	19
3.	**Partnership and planning**	**24**
3.1	Ownership in partnership	24
3.2	Core assessment teams	25
3.3	Dialogue	26
3.4	Partnership in the wider context	28
4.	**Assessment texts**	**29**
4.1	Assessment rationales	29
4.2	Assessment format and the evidence base	30
4.3	Ticking boxes – the accredited witness	31
4.4	Witness reliability	35
4.5	Increasing the evidence base	37
4.6	Towards the integration of theory and practice in the assessment of nursing competence	41
5.	**Practice placements**	**44**
5.1	Introduction	44
5.2	Contextual issues	44
5.3	Assessment and learning events	49

6. Monitoring – towards the learning institution **61**

6.1 The need for effective monitoring 61

6.2 Revealing the issues 63

6.3 Learning from monitoring 66

7. The role of dialogue in the assessment of theory and practice **69**

7.1 Introduction 69

7.2 The role of dialogue in assessment 69

7.3 Constructions of knowledge 69

7.4 The assessment of knowledge 72

7.5 Strategies for improving the assessment of knowledge 74

7.6 The function of dialogue in the learning and assessment of reflective practice 75

7.7 Structures and mechanisms for dialogic assessment 77

Epilogue **79**

Recommendations **81**

References **93**

Bibliography **94**

Appendix I **99**

1.1 Introduction

Although the assessment of competence in nurse and midwife education is formally a matter of concern for national policy-makers and government, it is those who work 'on the ground' in the health services and higher education who have the most immediate interest in its effectiveness. The primary objective of these senior and middle managers, educators, and nurse and midwife practitioners is to ensure that patients receive high-quality health care; consequently, any time invested in education and assessing new practitioners must significantly contribute towards the development of that quality. This report considers education and assessment with this in mind and offers an account of assessment practices well suited to the development of quality care. It sets out a case for assessing students' competence in ways that make it more than just a 'bolt-on' activity, but which create instead an opportunity for facilitating improved competence in the health service at all levels.

1.2 To whom does the research report have something to say?

This report is intended for three groups of reader. Firstly, it is addressed to clinical and educational managers to whom it offers an account of some highly effective ways of cultivating quality health care through quality education. It provides them with a well-researched rationale for incorporating educative assessment within the broad context of health care. The report is also addressed to co-ordinators of teaching teams and leaders of practitioner teams. To them it offers details of the relatively minor changes necessary to establish assessment structures and mechanisms that will promote educational dialogue capable of leading to changes in the practice of both students and established staff. And, finally, it is addressed to teachers, nurses and midwives. It provides them with a picture of the characteristics of mutually educative assessment and compares the schedules and documents used for such assessment with some of the other time-consuming and far less effective ones currently in use.

Senior managers of health service institutions, particularly the personnel and business managers of hospitals, trusts and community practices, must be confident that their organisations can offer a competitive service. For this they must have a well-qualified and reliably accredited workforce capable of delivering safe and flexible quality care within the constraints of the resources available. This report offers senior managers evidence that the practice of established staff is more flexible and innovative where institutions undertake to work with students in an education and training partnership designed to benefit both sides. It sets out the implications for the organisation as a whole, and indicates where management can help create the conditions for mutually beneficial assessment and education.

The chief concern of middle managers is not competitiveness in the market but effectiveness in the clinical environment. Ward managers, for instance, need to be certain that new colleagues can be trusted in situations where they have to make judgements and take decisions. They also need to know that novices are capable of working harmoniously as part of a team. The report suggests the significant part they themselves have to play in supporting students and established staff as together they develop knowledge, skill and understanding. It offers evidence of some of the most effective ways of achieving this.

At the grassroots, the first responsibility of nurses and midwives is to care for clients. Even the extremely important activity of teaching and assessing students comes second to this.

Mentors and assessors need a realistic and manageable assessment programme that enables them to support students in a highly pressured practice context. Despite the difficulty they sometimes experience in finding time for teaching and assessment in a busy care schedule, most spare no effort in helping students. So for practitioners it is most important to know which forms of help are most productive and which a waste of time. The report documents practitioners' dissatisfaction with the quality of liaison between themselves and academic teachers, and examines some of the ways this might be improved. It examines, in particular, the different ways evidence of competence is collected and explores how clinical practice is enhanced when assessment documentation leads to discussion about clinical practice in general.

Curriculum planners and programme managers must be able to evaluate the effectiveness of the teaching and learning for which they are responsible. On the one hand they have to account for the credibility of extant programmes, and on the other they need information for future curriculum development. The report addresses their concerns by indicating criteria for evaluating the success of particular programmes in fulfilling an educational function through formative assessment. It also reveals how the curriculum is affected by planning, evaluation and various frameworks for assessment. Finally, it offers a comprehensive account of the structures that promote the sophisticated analysis of theory and practice in relation to each other.

Nursing and midwifery teachers are the people who are perhaps best placed to encourage students to develop the spirit of enquiry which will sustain them in asking questions and challenging taken-for-granted practices. The research shows that students sometimes lack confidence in pressing clinical staff to discuss assessment criteria with them, and, as a consequence, they do not always fully recognise where their strengths and weaknesses lie. It reveals the need for students to acquire the all-important capacity for critical self-assessment, showing how this can be encouraged through dialogue between student and mentor/assessor in the clinical area, and between students and teachers in the classroom. It sets out various ways of achieving that dialogue through communication practices that emphasise the critical appraisal of knowledge. It provides a large sample of comments from interviewees which may be used directly with student groups to initiate such a critical reflective dialogue.

While the report speaks individually to each of the named groups, it has as one of its purposes the encouragement of discussion *between* groups. The research on which the report is based examines discussion in the context of assessment and reveals a pressing need for informed cross-professional discussion in professional learning in general. By showing the benefits to be gained throughout the health service from ongoing educational debate about current and future health care practices, the report hopes to encourage teachers, practitioners, curriculum planners and clinical managers to develop the quality of the dialogue between them. It is, therefore, addressed to these audiences both individually and severally.

1.3 Professional competence and subjective assessment

The report highlights the difficulty practitioners have in agreeing precisely what constitutes professional competence, although most believe it to be far more than technical skill. Qualified clinical staff have a wide range of perceptions about what counts as practical competence and an equally diverse set of views about what counts as relevant knowledge; teachers have another set of ideas, particularly with respect to knowledge. The research demonstrates that two people are rarely looking for exactly the same thing when they assess a student's competence. One assessor may see a particular student as 'careless' because they leave one task to begin another the student has judged more urgent, whereas a different assessor may perceive this as showing that they are 'capable of taking initiatives'. One assessor may evaluate a student

as highly competent because they are able to demonstrate confidence and ability with particular skills in a specific environment, another may decide that the student's understanding of the principles is insufficient for them to be considered competent in a different environment. The report reveals that real people in real contexts do not see things in a uniform way, that they interpret what they see, hear and read in ways that draw on their own experience as well as on the authorised frameworks for assessment found in guidelines and schedules.

There are two ways to see the subjectivity of assessors' judgements about competence. On the one hand it is possible to throw up our hands in horror and clamour for increased standardisation in assessment instruments in an effort to try to rule out the human factor and 'guarantee' something that appears (falsely) to be objectivity. Subscription to that particular point of view would mean bowing to pressure for the use of long lists of pre-specified skills which contribute to each particular competence. It would require that the list be ticked to show that each skill had been demonstrated before a student was deemed to have attained that competence. But the research in this report suggests that no greater objectivity is actually achieved by using allegedly standardised lists of sub-skills. This is because all those concerned in compiling and using assessment schedules bring their own interpretations of competence to bear so that no schedule can ever be 'assessor proof'. Written statutory guidelines are interpreted in relation to situation-specific, real-life nursing and midwifery events.

The alternative approach, advocated in this report, is to accept that judgement is an element of professional competence and that to try to legislate subjectivity out of existence would be to attempt to replace a context-sensitive judgement of quality with a context-insensitive count of 'things done'. This response requires us to seek ways of taking the subjectivity of assessor perceptions into account, so that the assessment of competence can be regarded as both valid (because it is context-sensitive and involves the judgement of experienced practitioners and teachers) and reliable. It demands that we abandon the myth of objectivity and find a means of replacing it with assessment structures and mechanisms that take full account of the fact that the best we can manage in any assessment is a judgement based on multiple subjectivities, that is, on the subjective perceptions of a number of different people.

The research provides convincing evidence that through the experience of working with concepts of competence and addressing the issue of what counts for assessment purposes, teachers, assessors and students themselves eventually achieve a coherent understanding of it. In the course of their work they 'test' the theoretical concepts embedded in statutory texts through their practice and the accounts they share. Concepts of competence are constructed from a multi-dimensional perspective and developed through individual reflective practice within a reflexive institutional culture.

1.4 Educative assessment

Mutual education

After examining practice in many institutions, the report argues for what it calls 'educative assessment'. There are both idealistic and pragmatic reasons for advocating assessment as a means of promoting education amongst practitioners as well as students. Education and its assessment directly affect the quality of practice and also indirectly influence the allocation of resources to facilitate it. Good professional education ensures that hospitals and community practices receive thinking, independent and adaptable new recruits, and adds value to these institutions by helping to develop the skills and understanding of current practitioners. Health care institutions able to demonstrate that their staff are highly competent can expect to attract the funds necessary to maintain the quality of service they provide; this is also true of teaching

institutions with regard to their students. The assessment of knowledge, skills and understanding is therefore of major importance in the achievement and maintenance of advanced educational and clinical practice. But just as importantly, it is the chief means by which role strain can be reduced for the nurses and midwives who have to be teacher, assessor and practitioner.

As the primary task of the nurse or midwife is to offer quality care, it follows that the time they give to teaching and assessing should add to their ability to care rather than place an additional burden on it. The report identifies the role strain experienced by mentors and assessors. It shows an overriding need to make current professional support and development structures more effective all round. The report argues from the extensive case study research that problems such as role strain can be relieved if the assessment of student competence is made to perform an educational function for *everyone* involved in the assessment. The research explores some of the ways that strain is relieved by making assessment a form of mutual education. It highlights the need to facilitate that process through the deployment of education staff in clinical areas to give practical support to clinical practitioners and to help them explore their own understanding of the complex mix of knowledge, skills and values which constitute competent practice. It examines the potential of such occasions to develop mutually beneficial relationships through which the needs of the assessor as well as the student can be addressed in a collaborative dialogue.

Evaluating quality

The report examines closely the schedules used for assessing competence in the practice environment and the criteria used for assessing written assignments. To be able to evaluate practical competence in occupational settings and to determine the extent that appropriate knowledge has been internalised by the student practitioner, assessment must examine the quality of a student's knowledge, skills and attitudes. Quantitative approaches to assessment are suitable for collecting information about outcomes within highly controllable contexts and for collecting information which can be measured or recorded as having been observed. They are inappropriate, however, for assessing the degree to which the student has developed a sufficiently flexible and responsive approach to ensure intelligent independent behaviour in dynamic practical situations. Most clinical managers agree that it is these latter qualities which they most value in their staff; the research offers them evidence that any investment of time they make in enabling their staff to work with the slightly more time-consuming qualitative assessment schedules will be repaid handsomely.

Educative assessment takes full account of the fact that there are actual individuals involved who are not automatons, but people who interpret and make sense of what they encounter in terms of their experience; its structures are generated in response to this fact rather than in contradiction of it. It offers structures, mechanisms, roles and relationships that reflect interior processes and take into account the essential 'messiness' of the workplace. If assessment is to help students develop their theory and practice as fully as possible, then it must address the real clinical and classroom worlds rather than the 'ideal' ones. From the research we draw the conclusion that this means assessment activities must be capable of collecting sufficient evidence to enable an assessor's judgement to be the subject of a dialogue between themself and other concerned parties, including the student and their teacher. The collection of evidence must also involve more than one 'accredited witness'. Teachers are encouraged to work with each other, students and practitioners to re-evaluate the appropriateness of the assessment instruments and processes used to determine practical and theoretical understanding, and to find ways of adapting them to create a more effective dialogue about the evidence on which judgements are made. What is being assessed, how it is assessed and why it matters will become a matter of constant debate between teachers and students.

In the 'learning institution' learning and assessment take place alongside each other and are integrally related. The learning institution is the environment where education occurs, but it is also itself learning through a process of action, analysis, critical reflection and further action. It provides a context for the development of competence but is continually modifying its perception of what constitutes appropriate competence as the context changes and evolves in response to what happens when learning and assessment take place. The learning institution has structures and mechanisms for encouraging reflection on these processes which in turn is able to affect the processes themselves. Since formative assessment is closely allied to work processes, its proper use facilitates the internalisation of reflective practice. The learning institution has a tendency to provide support for formative assessment by offering encouragement and support through the establishment of organisational patterns that allow continuity of contact and time for conversation and reflection. By monitoring its activities, it develops a set of principles for learning and assessment that stresses interpersonal relationships, discussion and action. Individuals in the learning institution develop their ideas and skills as they attempt to 'do the job', learning its essential elements as they observe and work alongside colleagues.

Structures for dialogue

In a dialogic culture, practice is treated as something about which it is legitimate to argue, ask questions and explore alternative possibilities. In such a culture, monologue-with-an-audience, in which what counts as competence is presented for students to copy, is replaced by a sharing of ideas and understandings about it that draw on accounts from theoretical perspectives, as well as both generalised and situation-specific contexts of practice. In a dialogic culture, people talk to each other about the values and theories implicit in their world. Although all organisations have a variety of communication networks which have the potential to promote learning conversations, some are more likely than others to assure dialogue. Hierarchical, line-management networks, with their largely univocal, unidirectional form of communication, offer prominence to the official 'voice' and seek to promote a single perspective about issues with an organisation-wide significance. The members of flattened hierarchies and collaborative task forces strive more often to share their understandings and misunderstandings. In dialogue between more or less equal partners, the internalised criteria which have enabled the student and practitioner to reflect in action and so act on a day-to-day, situation-by-situation basis, can be brought to a level of consciousness that makes it possible to generalise that knowledge and use it in analogous situations.

The market and professional discourses

This report is the story of how nursing and midwifery cope with the dilemma created by the fact that they are services for which the quality of the outputs depends entirely on the quality of the processes, and that therefore two discourses which seem at first to be diametrically opposed are in fact interdependent. The market discourse envisages a perfect product, requiring comprehensive surveillance systems to assess the performance of the producers and to measure the standard of the individual components, skills, competencies or outcomes. The professional discourse, by contrast, values professional judgement and decision-making, both the product of reflective practice and critique(al) dialogue. What follows from the debate about market models and professional development process models of work, when that work is the professional work of nurses and midwives, is a discourse about knowledge itself. The professional process discourse recognises the uniqueness of individuals and their organisations and avoids generalisations. Rather, it seeks to establish structural dialogue and the research-based cycle of assessment and education. This involves the collaborative collection of evidence, dialogic

reflection upon that evidence, the interpretation of these reflections in terms of learning, occupation and education – discourses which place caring itself back at the centre of the agenda.

1.5 The setting up and operation of the research

The issue of developing and implementing adequate assessment strategies for nursing and midwifery education programmes has challenged both state bodies and educators across the world for over fifty years. The Assessing Competencies in Nursing and Midwifery Education (ACE) project was set up to report on current experiences of assessing competence in pre-registration nursing and post-registration midwifery programmes. Nursing and midwifery have undergone rapid and far reaching changes in recent years, both in initial educational requirements and in the demands being made on professionals in their everyday work. The report is intended to contribute to current developments in educational programmes to help professionals to meet the increasing demands being made upon them.

ACE was funded by the English National Board for Nursing, Midwifery and Health Visiting during the period July 1991 to June 1993. It was based at the University of East Anglia and conducted as a joint project between the School of Education of the University of East Anglia, the then Suffolk and Great Yarmouth College of Nursing and Midwifery (now amalgamated with the Suffolk College of Higher and Further Education), and The Suffolk College of Higher and Further Education.

The focus was on the assessment of competence of students on pre-registration nursing programmes (diploma of higher education (all branches) and non-diploma) and 18-month post-registration midwifery programmes (diploma of higher education and non-diploma). The project conducted fieldwork in nine colleges of nursing and midwifery and their associated practice placement areas, in the three geographical regions of East Anglia, London and the North East.

There were two phases. During the first phase data were collected in all nine approved institutions to identify issues of national importance operating in their local contexts. Issues related to the whole of the assessment process were explored, including planning and design, assessment experiences, monitoring and development. At the end of this phase, an interim report was written which provided a means of articulating initial findings and of firming up the research questions for the second phase; this then directed the collection of relevant data in greater depth in a smaller number of fieldsites. This approach is generally known as 'theoretical sampling' which produces 'grounded theory' (Glaser and Strauss, 1967).

Project aims

The aims of the ACE research project were:

1. To establish the effectiveness of current methods of assessing competencies and outcomes from education and training programmes for nurses and midwives.
2. To examine the relationship between knowledge, skills and attitudes in the achievement of competencies and outcomes.
3. To establish the extent to which profiles from the assessment of individual competencies adequately reflect the general perception of what counts as professional competence.
4. To investigate the feasibility of simultaneously assessing understanding, the application of knowledge and the delivery of skilled care.
5. To collect perceptions of the usefulness of the UKCC's interpretive principles in helping nurse and midwife educators to assess competencies and outcomes.

The methodology of the ACE project is qualitative, focusing upon structures, processes and practices as these were revealed through case studies built from data such as documentation, interviews and observations. By a process of comparison and contrast, key groups of structures, processes and practices were identified as a basis for the more formal analysis of events.

Alongside the strategies for the gathering of data and their analysis were strategies to ensure the 'robustness' of the data and their interpretation. These included the use of an expert 'steering group', dialogue and feedback with participating staff and students, theoretical sampling, the application of the triangulation of perspectives and methods, and reference to research output from other projects. The sensitivity of the methodology, with its emphasis on communication and personal contact, was a feature, and attention to principles of procedure facilitated fieldwork relationships.

Methods of data collection were:

1. In-depth interviews (individual and group) with students, clinical staff, educators and other key people in the assessment process. Recordings of interviews were transcribed for analysis.
2. The observation of assessment-related events in clinical and classroom settings.
3. The creation of an archive of assessment-related documentation from approved institutions.

The result was a large text-based archive constructed from interview transcriptions, observational notes and the documentation of programmes, planning groups and official bodies. The method of analysis involved strategies of concept analysis and discourse analysis through which key ideas and debates were identified from professional and student discourse communities. This in turn provided a means of identifying the institutional, local and national structures necessary for the construction and delivery of assessment. A separate structural analysis was made of particular approaches to identify the roles and associated mechanisms and procedures through which events (both intended and unintended) were affected. These events in turn were then analysed into their stages, phases and process features in order to identify what counts as professional competence in action, and to compare this with what was proposed in policy curriculum documents.

Issues of mutual education, quality, evaluation, structures for dialogue and how to develop learning within the institution have been matters of concern for those with responsibility since at least the initiation of pre-registration diploma of higher education (Project 2000) programmes. This report addresses those concerns and offers a focus for discussion. It is not intended as an authorised version but as something to start conversation.

2.1 What is competence?

Statutory competence

Statutory competencies for nursing and midwifery (Rules 18 and 33 respectively) have been in place since 1983 with the introduction of the Nurses, Midwives and Health Visitors Act. These statutory requirements guide individuals as they attempt to come to an understanding of the concept of competence:

> *'Well, we have criteria as a midwife, we've got a set of rules, a code of conduct . . . rules that we have to follow and your practice has to be safe otherwise you wouldn't be following those rules, so that's how I judge my competency . . . this is what you . . . have to be able to do to be a midwife.'*
>
> *(midwife)*

As this midwife makes clear, statutory guidelines can constrain the way in which a conceptual map can be drawn up; they can also broaden them, however. If we take nursing as an example, we can see how Rule 18a has constructed competence as a broader set of things to be achieved than Rule 18. Under Rule 18 students must:

> *'b) recognise situations that may be detrimental to the health and well being of the individual'*

However, for students to fulfil this particular focus of competence under Rule 18a, their understanding of factors detrimental to health requires greater scope and detail. They must demonstrate the following:

> *'a) the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability or ageing for the individual, his or her friends, family and community;*
>
> *b) the recognition of common factors which contribute to, and those which adversely affect physical, mental and social well being of patients and clients and take appropriate action;*
>
> *d) the appreciation of the influence of social, political and cultural factors in relation to health care'*

These revised statutory competencies for diploma of higher education programmes incorporate new educational aims, placing greater emphasis on professionality. Nurses and midwives are expected to demonstrate competence through:

> *'c) the use of relevant literature and research to inform the practice of nursing'*
>
> *'e) an understanding of the requirements of legislation relevant to the practice of nursing'*

Statutory definitions of competence provide set criteria for assessment in order to ensure that standards are met. There is a danger, however, that they will be interpreted narrowly and hence shape the concept of competence in terms of the minimum standard necessary to

meet the assessment requirements. In this way, fulfilling the assessment criteria defines competence, but anything not defined in the assessment criteria can become in effect 'worthless'. Just as IQ has been defined as what IQ tests measure, so competence can be defined as what assessment procedures measure:

> *'We're competent as a qualified nurse because we've satisfied the system that requires us to demonstrate it. We've passed the assessments etc. so therefore we are competent. That's one definition.'*
>
> *(education manager)*

This points to two very real assessment issues. How much of assessment is about bureaucracy rather than judgement or education? How do personal understandings about competence 'fit' with those defined through assessment documentation?

To answer these questions we should note that during the ACE project, whilst some interviewees identified the statutory competencies within their own understanding of competence, others expressed worries about statutory definitions being perceived as minimum standards, where no reflection and development occurred once the 'basics' had been achieved:

> *'. . . they're a good springboard for further development, but I would challenge anyone who sees them as the be all and end all, or who always points to the competencies and says as long as a nurse can do that she is therefore a nurse.'*
>
> *(educator)*

> *'. . . if it's a statutory requirement then it cannot be ignored . . . I think there is a danger that they become the benchmark . . . I would see it as a minimum gateway that you get through some time during the course, but there's far more to be achieved than that . . . there's a great difference between the statutory minimum requirements and what can be achieved even within the diploma level course. And I guess if you went around the country and looked at all the different courses that they all probably fall at different points within that . . . I know there are some . . . that . . . just achieve the minimum requirement and that's it, but I know there are others that I'm sure are much more innovative than that.'*

If statutory definitions can be regarded as a 'minimum' to be attained or as a 'springboard' for development, there is a danger that teaching and learning may be addressed to the minimum rather than to developmental opportunities.

Components of competence

Interviewees talked about competence in terms of it being broken down into 'components' considered to contribute towards the whole. These components clustered into categories:

- wide range of skills:
  - practical/technical
  - communication
  - interpersonal
  - organisational
- safe practice
- up-to-date knowledge base

- critical thinking
- membership of a team
- professional attitude
- motivation and enthusiasm
- confidence.

This list is not exhaustive, but illustrates the range and kinds of components interviewees described. Each of these components may be further broken down into sub-components in what may well become an infinite series of 'bits'; this is a feature of the behavioural approach. However, upon closer inspection, many of the 'components' of competence referred to by interviewees seem to resist exact definition. Here are some examples:

- *'professionals first and foremost'*
- *'you've got to keep yourself aware of changes in current thinking'*
- *'good practical skills'*
- *'tremendous self-awareness'*
- *'safe . . . who admits when they don't know something . . . and goes to the right place and finds out who to ask'*
- *'enthusiastic and eager to learn, wanting to develop new skills . . . personality counts for a lot'*
- *'an adequate knowledge base'*
- *'the ability to provide a high standard of care . . . not only meeting the mother's physical need but also her psychological needs as well'*
- *'communication skills . . . it's being a patient's advocate'*
- *'motivation . . . and to be able to take an interest in ward activities'*
- *'thinking – if you want just one word it's about thinking'*
- *'able to show empathy with relatives or carers'*
- *'you can be competent at knowing what to do, competent at knowing how to do it . . . but it's really knowing why you're doing it'*
- *'using your resources suitably'*
- *'good with staff and able to help, see that somebody's drowning under a lot of work . . . to go in and help and guide them through, support . . . a supporter'.*

It may be possible to itemise what constitutes 'good practical skills'; it is even possible to regard keeping up-to-date with 'changes in current thinking' or having 'an adequate knowledge base' as observable and measurable elements. It is more difficult to define 'tremendous self-awareness', regarding oneself as a professional 'first and foremost', or 'thinking' in the same way; these point towards a more holistic conception that implies processes of interpretation and judgement. All the so-called components could be reinterpreted as features of a multi-dimensional holistic map, not reducible to bits but integral to the work process as it reveals itself in concrete practice. Nevertheless, a focus upon particular skills and qualities as discernible 'bits' or 'elements' required for good practice is a common way of talking about practice whether or not that practice can actually be itemised and quantified.

From an ethical point of view, the attitude of working to satisfy minimum criteria cannot be regarded as professional. Professional action is effective action. Effectiveness does not work toward, nor is it satisfied with, minimal criteria. Rather it works according to criteria of continual improvement in professional action. In this view, competence is always developmental in orientation, never looking back to the minimal criteria but always looking forward to better performance, improved decision-making and greater quality of outcome.

Competence continues to develop and grow as the individual begins to construct a more detailed picture of the general requirements of nursing or midwifery by building up a repertoire of situation-specific experiences. Competence is, therefore, a concept which is worked out and continually reformulated through work itself. Assessment needs to take account of all these complexities.

2.2 Assessment as supportive critique

Self and peer review are procedures that contribute to the development of a reflexive body of professional knowledge, grounded in shared experience. They facilitate a personal understanding of the processes of professional judgement and evaluation. Some interviewees focused upon these activities as professional competencies in their own right. They talked about nurses and midwives developing their own standards, and being ready to assess themselves. They saw the development of competence as an ongoing process which takes place in a relationship of mutual support and critique with colleagues.

> *'You have to be self judging . . . as well as your peers judging you . . . so if you feel you're achieving those competencies yourself, then you're in [a] position to judge someone else.'*
>
> *(midwife)*

Such imprecision may disappoint those who want to measure clearly-defined signs of competence. Yet what is being judged is imprecisely defined because it is not a single entity but rather a complex of concepts, perceptions, feelings and values that constitute an orientation, a focus and a rationale for acting:

> *'I feel a lot of the time nurses lose sight of the prime reason that they are there – and that is the patient. Because it's so easy to do because there's so much else going on. And a professional person is able to constantly pull themselves up and say, "Now hang on, what am I doing? Where am I going? It's not good enough just to measure myself against the competencies and say, oh well I come up to that standard".'*

Clearly, a defined set of competencies is inadequate to generate the sense of competence that is being described here. Such a view requires a sense of continuous assessment of action, indeed a sense of mutual assessment:

> *'. . . I mean I think we all assess ourselves and our work colleagues continuously, all the time anyway . . . the team leader will look at her staff . . . and know who to shout for if there's an emergency. And that way she's assessing her staff isn't she, as she goes on . . . you assess people by how they go about their work, how organised they are: Are they tidy? . . . Are their patients happy? . . . Are they lifting patients that are in pain without analgesia and that sort of thing.'*
>
> *(student nurse)*

The view of assessment as supportive critique is an important one which requires further exploration. It is necessary to discover, for instance, the extent to which that kind of critique is possible given the pragmatic (e.g. time) and cultural (e.g. 'busy-ness') constraints in nursing and midwifery environments, and also the extent to which these constraints affect everyday competence.

Some interviewees suggested that the competence of the qualified practitioner becomes such that the component competencies are no longer distinguishable, having become features of performance in general. They pointed out that these features are so embedded in the practitioner's daily activity that it is often difficult, if not impossible, to articulate them as specific competencies (Benner, 1984):

> *'. . . some of the skills come with experience of life and I think intuitiveness. I could work with a student and I could say, "What do you see in this patient?" and the student could say, "Well she looks fine." Now intuitively I might say, "Well I don't think she is" and I can't explain why I think that. It's come with experience . . . so* ***that*** *I don't think can be taught. That is something that has to be acquired . . . as they go on.'*
>
> *(staff nurse)*

This view of competence firmly centres it in work and work relationships. At its broadest, 'work' can be defined as the process of manipulating and transforming physical and social environments for human purposes (Sayer, 1993). Work as the dominant means for people to structure their lives, find self value, form a sense of identity and engage in relationships with others is fundamental not only to self-development but also to cultural and professional development (Lane, 1991). Competence, then, and the forms of knowledge and knowing and acting that underpin it, can be defined as expressions of work. The concept of competence as an expression of work seems inextricably linked also with a concept of continual development.

2.3 The development of competence

As understandings of competence and expectations of role develop, notions of the appropriate outcomes of programmes need also to change. A newly registered practitioner may be able to take on certain kinds of work expectations but may not be considered fully competent in their new role until they have begun to consolidate their course-based knowledge in relation to an extended period of work. As one educator commented:

> *'. . . I have got feelings that we are expecting maybe too much to say that at the end of training the student is a competent practitioner. And you would say that perhaps a student becomes a competent practitioner when they have had sufficient time, and that's got to be individual, to consolidate their overall training in a specific area [in] which they choose to work.'*

Even given time for development, however, there is not necessarily a linear progression in competence from level to level. Development is often not orderly and its pace is certainly not open to external regulation. Seen from a developmental perspective, competence can be conceived in terms of individual readiness for transition to competent practitioner status. This means, as the nurse quoted below suggests, that there is no externally pre-specifiable point at which it is possible to say for each and every individual that competence has been fully accomplished with respect to every aspect of nursing or midwifery.

'And I don't think that in three years of training a nurse has even approached perfecting those sorts of [interpersonal and communication] skills – if she ever perfects them – but she certainly hasn't even begun . . . So things like the skills you need to be self-aware and to have good interpersonal relationship skills takes years and years . . . to build up, to define and refine.'

It also means that the maintenance or development of competence is not guaranteed, and that competence is on a continuum along which it is possible to move backwards as well as forward:

'I think it's transient . . . you glide in and out of competence and I don't think you have it for ever and a day . . . and yet our notion of it really is that when you're competent that's it and you always are forever more.'

If this is the case for registered nurses and midwives, then it is certainly true for students, whose development is taking place within a time-limited diploma of higher education programme, and whose learning still remains to be consolidated by extensive experience. Work situations are dynamic, and the situationally specific events of everyday experience are not precisely controllable. The experience of being competent to handle such situations is thus likely to fluctuate according to the sense of being in control, knowing what to do next and handling the unexpected. Thus:

'It's not an all or nothing state is it? . . . [Students] are partially competent and I think most practitioners are only partly competent.'

In this view, then, competence is not a steady state; it is a fragile achievement and never a total accomplishment.

'I mean to be competent as a nurse do you have to be competent in everything? Because I'm not competent then . . . Because applying it to my own situation there are a range of skills that I have to bring to my job. There are some I do well, I think, there are some I can handle reasonably well, and there are some I'm quite poor at. What I tend to do is delegate the poor ones, avoid them myself. So am I competent or not? I'm competent in the areas in which I practise, but because I avoid the areas where I might not be, does that keep me competent?'

But while the professional development view defines competence as something which continues to evolve over time in fits and starts rather than by linear progression, it nevertheless recognises a sense of purposeful direction, a sense of striving to improve action in professional work.

2.4 The purpose of assessment

There are four kinds of purpose that need to be considered when thinking about assessment:

- technical purposes
- substantive purposes
- social purposes
- individual developmental purposes.

Technical purposes

The essential technical purposes of an assessment procedure are reliability, validity, fairness and feasibility in what it assesses; also to provide feedback to the student, the teacher, the institution and national and professional bodies to ensure the quality of the programme.

Substantive purposes

The substantive purpose of a nursing or midwifery programme includes a grasp of the appropriate knowledge bases as well as the accomplishment of appropriate degrees of practical competence in occupational settings. The question of who should decide what counts as an appropriate knowledge base and an appropriate level of performance are made more complex with the advent of local decision-making. At a local level, market forces may lead to the tailoring of programmes to meet local needs. The question arises, then, how national standards or levels of comparability can be maintained. A professional trained to meet the needs of one area may be inadequately trained to meet the needs in another part of the country. Substantive issues are thus vital to maintaining a national perspective not only on professional education but also on professional competence.

Social purposes

At a social and political level the public needs to be assured of the quality of professional education. Assessment in this case serves the function of quality assurance and can contribute to public accountability. However, there are other hidden (even unintended) social functions. To gain a professional qualification means also gaining a certain kind of social status. It means taking on not merely the occupational role, but the social identity of being a nurse or a midwife. With the role goes an aura of expertise, a particular kind of authority that can extend well beyond the field of professional activity into other spheres of social life. On the one hand, it can be argued that, through their authority, the professions act as agents of social control; equally, it can be argued that they act as change agents, raising awareness of, say, the impact of unemployment or poverty on health.

Individual developmental purposes

Work is still the dominant social means through which people form a sense of self-value, explore their own potential, contribute to the well-being of others and feel a sense of belonging. Therefore, becoming qualified to enter a profession marks a stage not only in the social career, but also in the personal development of the individual. Assessment is thus, in its widest sense, about human development, purposes and action.

To become a professional means that knowledge, skills and attitudes blend in the person to the extent that the individual's identity is bound up with professional activity. This is what makes both defining competence and its assessment so difficult to achieve. It is not just that the individual is perceived as a professional; the individual is perceived to have a mandate to act.

2.5 The persistence of the familiar

Devolved continuous assessment was introduced into nursing and midwifery education as a response to the need to assess a wider range of educational purposes and a developing concept of competence. Long-established cultural practices are not changed overnight, however, and the move towards devolution has been marked by a degree of culture clash. Where there is transition there is also variety, as new forms of assessment are introduced to run, for a time, alongside more traditional forms. Consequently, the experience of non-continuous, four ward-

based assessment has continued to affect the perceptions of assessment for some time after the introduction of the more educative approach.

Although many practitioners still cling to some of the ideals of traditional assessment with the consequence that the nursing and midwifery culture in specific locations within particular institutions has been slow to change, most when interviewed were clear about its shortcomings. The information people offered about their dissatisfaction with piecemeal, periodic forms of assessment is interesting from two points of view. Firstly, it confirms the general sense that nurses and midwives are, in principle, committed to continuous assessment as a 'fairer' means of gauging student competence. Secondly, it provides evidence of the fact that people can be aware of shortcomings and yet still continue to work for some time without complaint within a culture in which flawed practices persist.

One-off practical tests

Interviewees acknowledged that this approach was inadequate for the assessment of practical competence, particularly with regard to the following points:

1. Lack of reality

Interviewees made it clear that assessment focusing on the ability to perform satisfactorily on a one-off occasion within an essentially 'false' situation does not reflect the realities of everyday practice. Staff and students spoke of how a great deal of rehearsal occurred prior to the assessment. The following comments are typical:

> *'I don't always feel it's fair to the student really, because it's not real and when they qualify and they get out there it's so different . . . And I can remember thinking it, "But on my management it wasn't like this!" Everything went so smoothly.'*
>
> *(staff nurse)*

> *'You tend to do probably extra things that you wouldn't normally do.'*
>
> *(student)*

> *'. . . making sure the trolley's perfectly clean and that you've got everything on the bottom, where probably on a normal drug round . . . day-to-day you'd just look quickly then rush off with the trolley.'*
>
> *(student)*

2. Stress

Unsurprisingly, many students expressed anxiety prior to and during assessment events. As one student commented wryly:

> *'I suppose it assesses how to cope with stress . . . you're nerves are just shot to pieces. I'm not a particularly nervous person or highly strung . . . I'd hate to find someone who gets quite intimidated by it all . . . it really is horrible.'*

3. Limited application

Many students were concerned that the focus on one-off performances provided little opportunity to show what they knew about the principles of nursing or midwifery in a variety of settings. Others were concerned that success in a one-off situation did not guarantee transfer of competence to a variety of contexts:

'. . . like aseptic assessments, you can have an assessment on a dressing and can not have gone near a suture line or clips or anything and suddenly you're competent enough to go off with your trolley and take out clips and sutures and God knows what else on the ward.'

4. Poor discrimination of levels of performance

The limited capacity of the assessment to pass 'good' students and detect and where necessary fail 'poor' ones was noted by several interviewees:

'You do get referrals to people that shouldn't be referred, and you know are quite capable that have done something amazingly silly. But you know if they'd actually done it on a day-to-day basis you'd just say, "Well that's stupid, I've got to start all this again" . . . and then you get those who, you know to be honest don't really put in a great deal more than they have to on a day-to-day basis that come out with a glowing performance on the day.'

(educator)

Ward reports

The shortcomings of the King's Fund or 'ward report' forms used on students' practice placements as an adjunct to practical tests were seen as largely to do with the lack of real evidence that they provided:

'. . . the King's Fund report form is very . . . open and there's not a lot of room on it for comment.'

(staff nurse)

'Well, the thing is they're never used properly; I mean half the time they just tick and there's never any comment made at all, to reflect what the ticks are actually saying.'

(educator)

Final examinations

Many students had strong views about the inappropriateness of the final summative written exams in nursing, and the final examination papers and orals in midwifery. They were unhappy with their one-off nature and the associated pressures. It was also felt that an exam did not assess their nursing or midwifery competence, and was therefore seen as unnecessary as well as unwelcome. Typical concerns of students were:

'Personally I'm very bad at exams . . . I've always had very good or outstanding ward reports but on exams my marks are normally borderline or just over borderline, sort of 50 to 60 per cent . . . I get into an exam and I know what I want to put and I know it all, well I know quite a lot of it! But putting it down on a piece of paper's just something completely different . . . everything hinges on that day.'

'. . . that . . . really worries me, the fact that it comes down to an exam paper at the end of the day . . . The fact that I've passed the ward-based, the practical assessments and been deemed to be competent or whatever . . . comes down to the fact that at the end of the day [you must] pass the finals.'

The general attitude towards exams and one-off assessments is summed up by the student who, in advocating a more continuous approach, indicates what is missing from the traditional one:

> *'. . . you see it as a hurdle . . . some people thrive on hurdles and jump them. But a lot of people see them as a barrier . . . you've got to get through that barrier. If it was like continuous assessment, I think you'd keep yourself more aware of what you were doing and would be more willing to change your practice, not just as a student but you'd have that sort of framework, so that when you do qualify you're still able to look about at what's happening and change your practice.'*

He, like the majority of students, practitioners and teachers interviewed, saw examinations as being about something other than competence. Indirectly, such a perception reiterates the view that theory and practice are separate entities.

Interviews show that perceptions of the weaknesses of single-event assessment and the strengths of continuous assessment do not always lead to different approaches to the activity of assessing. It seems that for many a shake-up of approach is required if assessment is to be part of an educative process. There were comments that some schedules are still dominated by behavioural formats which do not adequately reflect the complexities of continuous assessment (Medley, 1984; Evans, 1987). In them, competencies are broken down into numerous parts or sub-skills in order to measure them on a pass/fail basis. They focus on techniques rather than 'complex' competence. It appears that 'technicist' approaches – or approaches that concentrate on procedures broken down into simple skills – are still evident in some continuous assessment documentation and hence they do not promote assessment of the 'complex' or 'higher order' competence that typically characterises a professional. The implication seems to be that in evaluating the effectiveness of various forms of assessment, there is a need to consider not only the forms themselves, but also the general methodologies employed within them.

In the same way that nursing and midwifery competencies have been statutorily defined but are modified and extended in practice, so the strategies for assessing competence are set down in official procedures but adapted 'on-the-ground' as they are put into operation. There is, for instance, a clear distinction in the Board's regulations between formative and summative assessments, whereas interviewees' comments provide evidence that some assessors employ all assessment diagnostically and formatively. And, despite the Board's clear distinction between 'single-event' assessment and continuous assessment, people talk about both in ways that suggest both forms of assessment are carried out in similar ways. All the interviewees had definite views about the nature and quality of different forms of assessment, and those views inevitably affect their assessment practices.

The part played in shaping continuous assessment by the 'residual' perceptions held by those still operating the earlier approach, albeit alongside the new one, and the often cynical attitudes these engender, cannot be ignored. The following comment encapsulates that cynicism.

> *'I'd argue that there's a conspiracy of passing people at the moment because if they judged it by their [clinical assessor's] values they [some students] shouldn't pass, they're not competent . . . but they know their values aren't what's being asked for, but they have to assess them . . . to say someone's not competent to do that you've got to know what you're talking about and their training may not have given [them that] . . .*

if you don't know you might as well put a tick because if you put "no" . . . they challenge you.'

The dilemma is summed up nicely in the following comment, as the speaker unfavourably compares preparation for the major attitude and practice shift needed to facilitate the radically different form of assessment required by devolution and continuity, with the preparation offered to people in industry who are about to undergo an innovation of similar proportions:

'. . . half of the people [assessors] or whatever number, have been trained literally as they work to operate within one system. We are then asking them to assess with a different philosophical view . . . [without] – apart from a 998 course here or there – . . . particular help to do it. If any industry was remodernising it would put in massive resources to change it to operate the new machinery. Nursing somehow hasn't put that [in], and, after all, assessing that they [students] are competent to practise in this new way when you've never practised in it – it's like asking me to judge something I know nothing about.'

There is clearly an issue of what constitutes an appropriate investment in resources for a major innovation.

Openness to change

Assessment, like competence, is an activity informed by an evolving concept. It is also an activity which is carried out regularly and thus becomes habituated. Where institutions have an openness to change that is culturally embedded, their assessment strategies and practices develop gradually and meet the educational needs of the profession. Where the imperative for change is entirely an external one which impinges upon a non-reflective institutional culture, the attempt to accommodate to that change is often traumatic, and the strategies adopted lead to piecemeal adaptation within an 'unready' context. By contrast, in a nascent reflective culture there is principled movement towards a form of assessment that satisfies the professional requirement that competence should be founded in the application to practice of appropriate skills, knowledge and attitudes. Institutional histories are therefore of considerable importance in determining the extent and rate at which a particular assessment strategy will succeed. The success of devolved continuous assessment relies upon the people who operate it having a sense of ownership, without which they will lack the necessary commitment and understanding to exercise effectively the increased responsibility it brings.

Assessment from the educative paradigm is integral to the learning process that generates individual development. Competency-based education stands provocatively on the bridge between the quantitative paradigm and the educative paradigm, still making up its mind about the direction in which it should move.

3.1 Ownership in partnership

Responsibility for the detailed planning of assessment strategies belongs to individual approved institutions. In theory that responsibility is determined by a set of Board guidelines, United Kingdom Central Council (UKCC) statutory requirements and EC directives. In practice, because every institution has a unique assessment history, there are marked differences in the approach each adopts to the design of assessment strategies to meet the Board's most recent requirements. Those who have already been operating continuous assessment informally for several years simply continue the institutionalised process of evolution and development; whereas those for whom the experience is a new one face a considerable challenge of innovation.

Where there are well-defined roles and structures that promote partnership between all the interested parties, the personnel involved in the design and subsequent implementation of an assessment policy feel a sense of ownership. Internal partnership rather than external legislative imposition ensures a comfortable fit between the needs of practice, teaching and learning, and assessment. The most facilitative structures enable rather than constrain the process of parallel curriculum and assessment policy design from the earliest possible opportunity. The most supportive roles are defined in a way that encourages dialogue, and brings together different perspectives and specialist interests in a mutually enabling relationship.

The team of core educators, practitioners and (less frequently) students which is responsible for planning a particular aspect of a programme will also take responsibility for assessment. This partnership ensures that, in planning its assessment strategies, a team considers both the educational agenda and the agendas of nursing and midwifery practice. Partnership, as the teacher below points out, avoids the pursuit of an 'ideal' strategy which is inoperable in practice:

> *'It will involve teachers, managers, practitioners, student representatives and any other person who has specialist knowledge about this particular issue that is going to be written about or discussed. . . . To write a curriculum with purely educationalists, I mean people tend to say that educationalists tend to live in the ideal world, and sometimes don't tend to realise the reality of the situation. It is fine to sit down and write the ideal curriculum, but in practice it can't be implemented. . . . But here we have always taken the view that education is a partnership between the college of nursing and the service area.'*

Partnership is not always easy, however, and sometimes it can become unbalanced with either the practitioners or the teachers having slightly more say:

> *'. . . the midwife teachers and the clinical midwives, they both need each other to function properly and so it would have been in my opinion very wrong for it to have been an assessment strategy designed by midwife teachers. It's got to be both sides . . . In fact we had just one midwife teacher heading up a small subgroup and there were three preceptors plus her, so in fact . . . the emphasis within that small team if you like, was more on the practising midwives rather than the midwife teacher.'*

'. . . I mean we say that the student owns the document, but they can't own it if they've not designed it really to their own use . . . as long as educationalists are designing the form then there's going to be problems. As soon as the clinicians design the form then there's going to be problems with the educationalists. I think until we can all sort of get together and speak the same language there will be problems won't there?'

The issue here is one of ownership. In a satisfactory partnership, because all the partners make a significant contribution to the design of the assessment strategies and documents they eventually use, all partners feel a sense of 'ownership'. Not all planning groups, however, achieve this. The comment quoted above reflects a view which was often expressed, and highlights the need for greater dialogue between educators, practitioners and students to promote shared ownership.

In a true partnership between practitioners, teachers and students, the relationship between planning and assessment is perceived as integral. Far from being something designed separately by educators and imposed on practitioners, or given an undue practical bias by virtue of an over-heavy practitioner input, assessment is seen as fulfilling both a curricular and a practical function. Where all the people involved in the design of the assessment strategy become 'owners', as in the instance below, the needs of practice, teaching and learning, and assessment are well balanced.

'. . . our experience has taught us you can't divorce assessment from the main curriculum planning, and you can't have curriculum planning taking place and assessment coming later. Our experience has shown us this is not on. So from 1990 you could say that we have had to work very very closely together.'

Implicit in this comment is the importance of ownership and the potentiality for alienation where one partner feels they have had something imposed on them which they do not own.

3.2 Core assessment teams

Policies, procedures and regulations for continuous assessment must, by virtue of having to meet validation criteria, be designed to reflect a shared institutional philosophy (ENB, 1990, p. 49). Even if this was not the case, it would make sense for institutions to rationalise their assessment approaches from time to time to reduce the potential for confusion, prevent the unnecessary duplication of work and promote shared understandings. Programme planning occurs to less than ideal time-scales, however, which can lead to the relegation of assessment to a low priority in relation to curriculum design. An assessment strategy created in such circumstances can easily be at odds with the curriculum, either because the strategy is poorly designed or because the curriculum itself lacks coherence, a factor that is only revealed once the assessment strategy is in place. Coherence, in this case, has to be created at the post-planning stage, with a consequent waste of human and time resources. With a sensible time-scale it would be possible to ensure that discussion about curriculum and assessment takes place in parallel at the design stage, and thereby to reduce the potential need to find ways of making a programme 'hang together' *post hoc*.

The need here is for structures which enable rather than constrain the development of coherent and integrated assessment policies. This suggests that what is required for all programmes is the creation of core assessment teams, headed by a member of staff in an assessment/examinations officer role whose responsibilities would include the provision of general

guidance and the facilitation of assessment activities. Where there are clear role definitions for each member of a planning team, a designated responsibility for ensuring that the system operates effectively and individuals are given appropriate support, assessment planning is highly effective:

> *'. . . we utilised the examination and assessment officer . . . within the college . . and we had a small group of midwives and him . . looking at all our existing assessments and we in fact drew up . . . certainly the practical assessments based very much on the . . . model that's being used for the Project 2000, because we found it fitted what we were doing anyway. . . . [It] applies to midwifery in a way in which we think we'll be able to utilise, that the students will understand, that the preceptors in the clinical field will understand.'*

The picture which emerges is of a planning team with well-specified roles which enable individuals to work together in a unified way. This again suggests that where assessment roles for team members are clearly defined and supported by a role-holder with specific responsibility for co-ordinating all planning activities, the outcome is more satisfactory than when roles are ill-defined, and tasks randomly dispersed amongst a set of individuals who have a range of other equally pressing activities as part of their role. The frustration of simultaneously juggling an assessment planning role with other equally demanding ones is summed up well in the following comment:

> *'When I was saying there are problems, I mean I think it's with the documentation in the first instance. It's difficult to . . . take a huge chunk out of people's work time to prepare documents, and you don't know where to start . . .'*

The functions of a person in a central planning role, focusing more or less exclusively on assessment planning and implementation, are suggested succinctly below:

> *'Who works best with whom? Who has got the particular experience? . . . very early on . . . you must divide, you must create a division of labour, a task, who is going to do what. How is it going to be done? By when is it going to be done? What standard are we expecting? What difficulties may arise? Who will sort out the difficulty? . . . We set that ground very early on so that it is really a partnership.'*

3.3 Dialogue

What becomes increasingly apparent is the need for continuous dialogue, facilitated by a person whose role it is to ensure the coming together of all those working on assessment planning. Where no such role exists, dialogue takes place in the margins, and assessment strategies which unite different perspectives and specialist interests (i.e. which bring together branches within a programme or, where appropriate, marry assessment principles for nursing and midwifery) are less evident. Without dialogue at all levels planning is carried out in 'pockets', and anomalies arise where none should exist. Even where there is dialogue, problems are not always easily resolvable, of course, as the comment below from a nurse teacher speaking about another branch of nursing clearly shows. Nevertheless, dialogue offers the best hope of achieving what the speaker calls 'compromise':

> *'. . . it was a question of compromising . . . they wanted 112 competencies and there was just no way that we were going to . . . go along with that because it completely went against what we were trying to achieve, which*

was an individual competency rather than one which followed a rigid pattern.'

Dialogue is also essential to minimise the discontinuity created by mergers and amalgamations of the old schools and colleges of nursing and/or midwifery to form new approved institutions. It facilitates programme planning, enables different experiences and developments to be successfully incorporated, and assists the redesign of assessment strategies in ways that draw on the best from previous developments.

Despite an obvious cost in personal time where there is little provision of structured time for discussion and dialogue, most people commit themselves fully to the planning activity necessary to harmonise previously disparate systems, as the quote below indicates.

'Ultimately what we finally did was we sort of put together the bits that were already being done here on this site, and quite a bit of work they'd already done at X college when we amalgamated . . . there were all these issues that we had to take on board . . . So that's how we came up with the scheme that we have now, with a lot of changes on the way . . . formats had to be changed to fit in with our current curriculum . . .'

The emphasis is on a complexity which requires 'quite a bit of work' if it is to be made sense of without resort to the simplistic. That work is made harder where the composition of teams is unstable because of the re-organisation process, and it becomes necessary to spend even more time ensuring common understandings.

'I was representing mental health in the team, and the team itself changed . . . a little bit over the development period because different people came into the college and different people had different jobs and so they came and went.'

Dialogue about assessment strategy design in approved institutions where principles and procedures are not yet fully united, has the knock-on effect of furthering professional development across the board:

'So we have this dilemma in that the college came together as a single institution and inherited various degrees of developed courses, some of which were still summatively assessed and others which were continuously assessed, which meant that you had teachers who were familiar with such processes and teachers who weren't. And the training circuits, in the clinical placement circuits you also had practitioners who were familiar with continuous assessment and those who weren't, which meant there was a need to level off right through the organisation.'

(educator)

The greater the diversity of the histories an 'amalgamated' approved institution brings together, the greater the demand for dialogue to expose and analyse differences of perception, and to promote institution-wide understandings.

Where the assessment histories of merging or merged schools and colleges are very different, or these institutions are at different stages in the development of their assessment policies, individuals are obliged to invest large amounts of their personal time and energy to achieve compatibility. They do this willingly where there are stable structures for dialogue and partnership, but experience frustration where the re-organisation process has resulted in destabilised structures and uncertain role-definitions. This seems to point to the need for a policy co-ordinator and assessment quality assurance role.

Following a review of literature on competence, Runciman (1990) set out a series of suggestions for those involved in programme planning and curriculum development, several of which reflect the findings of the ACE project research. Runciman suggests, for example, that:

> - *the nature of competence should be widely discussed*
> - *the extent to which learning outcomes can and/or should be defined in a precise and measurable manner should be debated*
> - *collaboration between educators, learners, employers, and practitioners should be established at an early stage in the planning of programmes and should continue as programmes develop*
> - *the advantages and the limitations of a competence-based approach to education should be debated.'*
>
> *(Runciman, 1990)*

The ACE project has shown that there are so many mediating roles and structures between national, regional, local and individual interests that it is only possible to achieve coherent policies for assessment by ensuring dialogue at all levels. It has revealed the importance of factional needs and interests in shaping the progress of assessment and has demonstrated where roles and structures have helped the development of understanding between factions, and where they have provided constraints. It has demonstrated that interpretation is inevitable, and by implication that opportunities for sharing insights or causes for concern can enable closer understandings and facilitate the development of an approved institution's assessment strategy. It has also shown that any framework for negotiation and facilitation must be sufficiently sensitive to particular needs and specific local circumstances in order to be able to cope with a demand for specific and unequivocal information at some points (particularly at the beginning of the design process) and for framework advice at other points. It has revealed, in particular, the need for important new institutional and regional co-ordinating roles for assessment policy, and for the establishment of regional and national forums for the exploration of assessment issues.

3.4 Partnership in the wider context

It is not simply at the local level that clearly-defined assessment roles and structures are appreciated, however; they are also valued at a regional and national level. There are many instances of a happy relationship between Board Education Officers and their local approved institutions, in which officer and approved institution are able to critique national guidelines as a route towards making sense of them and gaining the ownership mentioned earlier. This relationship recognises the scope for local interpretation of national guidelines and looks positively for creativity in the approved institution's operation of them. Where the relationship between the parties is genuinely one of partnership, guidelines are used as an enabling framework and the need for dialogue about different interpretations is fully recognised. Without such a relationship, assessment documentation, schedules and procedures are introduced in which no-one at the approved institution level has any faith. Inevitably these fail to provide reliable or valid assessment information.

4.1 Assessment rationales

To accord with national guidance issued by the Board, assessment strategies designed by approved institutions must ensure that students achieve separate pass criteria for theory and practice, and that the overall assessment strategy reflects a curriculum in which there is an inter-relationship of theory and practice (ENB, 1990, p. 49; 1993, p. 515).

In order to demonstrate that the Board's regulations have been satisfied, detailed assessment documentation is produced by each approved institution which gives an overall rationale, role definitions, definitions of the assessment categories employed, together with the required mechanisms and procedures for carrying through the assessments. The rationale offers a justification and a general framework for interpreting assessment events.

Approved institutions must recognise the multipurpose functions of assessment as outlined in national guidance and seek to address the need for quantitative and qualitative approaches. How this is accomplished in practice varies from institution to institution. One institution, for example, opens its rationale by stating:

> *'Assessment entails judgement and an attempt to evaluate. It may be characterised quantitatively or qualitatively. Assessment presupposes standards and is necessarily based on criteria, held by the assessor, who may be the student herself or an external agent. It is axiomatic that assessment is necessarily interpretative, and therefore subjective to some degree. Assessment procedures ought to seek to minimise this.'*

Assessment rationales must address not only national standards or requirements, but also individual developmental needs. Formative assessment is typically seen as addressing the latter, and summative assessment as addressing particular pre-defined standards. While formative assessment is typically not understood to be compulsory, summative assessment is, and failure to reach a specified standard at any point in the programme may, depending on circumstances, result in failure of the programme. Assessment documentation for practice placement areas combines formative and summative elements to produce a structure that fulfils the general rationale for continuous assessment. The intimate relationship between educational philosophy and assessment rationale is clearly illustrated in this example from one institution's assessment and quality assurance handbook:

> *'The curriculum philosophy addresses the benefits of a variety of learning experiences and, therefore, a variety of summative assessment modes is appropriate. The role of the student of nursing is seen to be [as an] active [participant] in her learning, therefore, formative self assessment and self direction are of paramount importance throughout the course. The student will be greatly involved in her own assessment. Opportunity for improvement in performance will be available to the student as part of the assessment process. This allows for rapid feedback and remedial action should this be necessary. It also enables the student to take on the responsibility for reviewing her own progress, and developing her ability for realistic self appraisal.'*

The question arises whether the format of assessment documents together with the mechanisms and procedures for the implementation of assessment are appropriate to fulfil such rationales. To what extent, for example, does student self-assessment feature within assessment texts, and how far are curricula which integrate theory and practice represented? The focus for discussion in this chapter, then, is on the relationship between assessment purposes and the format of assessment texts. This also raises the issue of the creation of evidence bases on which to make judgements about developing competence.

4.2 Assessment format and the evidence base

Assessment texts can be within the range of two extremes: those that are tightly framed in terms of specifying the categories to be assessed; and those that are loosely framed, providing guiding principles instead of specifying categories. A tight format for assessment of practice typically employs a standardised document where the categories are formed in advance of use, with each category being ticked, often indicating levels of performance or measurements of some kind. At the other extreme, a loose format employs less standardised documentation where the categorisation is determined after considerable reflection upon data derived from practice.

The chosen format of the assessment text itself structures relationships between assessor and assessee. Its principles and categories direct attention and organise the processes of reflection and judgement that have to be made in fulfilling the demands to construct an evidence base. It is important to ask about the nature, reliability and validity of the evidence base that is provided by the different kinds of format.

Figure 1 shows the relationship between tightly and loosely framed assessment formats. The vertical axis represents evidence bases: at the top are those that are high in openness to independent reassessment, adaptability to practical circumstances and that fit with professional perceptions of competence; at the bottom are those that are low in each of these regards. The horizontal axis represents the continuum between assessment formats that are tightly prescribed, aiming at standardisation, to those that are loosely prescribed, aiming to draw assessment categories from the situation itself. The figure shows that the tighter the frame the more restricted the evidence base, and the more it is standardised the less it provides evidence that is open to independent reassessment. Conversely, the looser the frame, the less it is open to standardisation but the more it accords with professional perceptions of competence in practice.

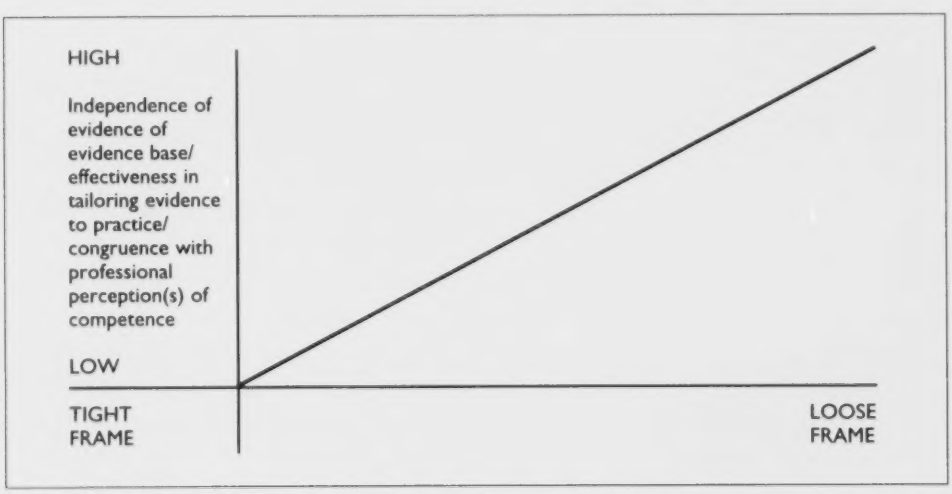

HIGH
Independence of evidence of evidence base/ effectiveness in tailoring evidence to practice/ congruence with professional perception(s) of competence
LOW
TIGHT FRAME
LOOSE FRAME

Figure 1: From tightly to loosely framed evidence bases

4.3 Ticking boxes – the accredited witness

No approved institution in this research project relied exclusively upon the simplistic tick box; however the majority did employ this format to some extent. Figure 2 illustrates the basic features of the format, using three items selected from 13. The choice, number and wording of areas for assessment, the items contained within each area and specified levels to be achieved varied according to programme and branch design. Assessment items were as broad as 'can undertake care plan' or were focused precisely on a well-defined behavioural procedure or aspect of a procedure. Note that the points in Figure 2 are actually highly complex: what, for example, constitutes 'sources of data'? This question alone would be substantial enough to generate a course in research methodology; to identify what constitutes a 'level' of achievement in being aware of data would be sufficient for several philosophy seminars.

A. Mental health branch

(Area) ASSESSMENT (Items)	(Level of achievement) 1	2	3	4	5
Awareness of sources of data	|	.....	.....	.....	..... |
Considers socio-economic, cultural, physical and psychological factors when carrying out assessment	|	.....	.....	.....	..... |
Utilizes theoretical knowledge during the assessment of client	|	.....	.....	.....	..... |

Figure 2: The ticking-box format

The format shown in Figure 2 is in danger of limiting the kind of evidence that can be collected to a mere categorisation of units of behaviour and only to those that are clearly observable and measurable. Once the box is ticked, the statement which gives significance to the tick becomes a surrogate for what actually happened. Even if deep discussion had taken place over these items, they would simply be reduced to a tick in the box; the same tick would be there even if there had been no discussion at all.

What an outside commentator cannot be sure of is whether what actually happened bears any relationship to what the statement alongside the box signifies. That is, there is no primary data of the interactions which led up to the ticking of the box. It is therefore tightly framed, but low on independent primary evidence capable of re-assessment for purposes of moderation.

Nevertheless, the tightly framed format is highly seductive, particularly where other forms of assessment format can be criticised as being too subjective:

> *'Now assessment was the same across the board in theory and practice, it was working quite well but . . . I accepted the ENB officer when they came and said . . . "A lot of this is open to a great deal of subjectivity in clinical practice." So really they tore our assessment apart. I mean I could see what they were saying and they said . . . in a clinical area you have to have skills that are measurable that a mentor [sic] doesn't have to think about, they just have to think, "Yes, they're achieved." They don't have to think, "Well, what level is the student at?"'*
>
> *(educator)*

This approved institution had been compelled into a tick-box approach, an approach that they were not happy with because it overlooked the multi-dimensional and dynamic nature of professional competence.

Of course not just anybody can tick the assessment document. It is to be presumed that the individual who does this is considered competent to make the appropriate judgement: such an individual is in effect an *accredited witness*. Nevertheless, as considerable reliance is placed on this role, it is important to examine and to question the extent of the responsibility.

In practice, items such as those in Figure 2 are open to considerable variation in interpretation; this at once undermines the reliability of the accredited witness role and necessarily subverts the very standardisation that is intended.

> *'. . . each nurse has their own view of looking at it . . . they might bring up something else that another mentor maybe didn't think of . . . say for organisational skills, one person might think [in terms of how] she's organised in herself when another person might look at it as how she organises the workload on the ward.'*

Educators were also aware of this issue and highlighted the importance of increased dialogue about assessment issues as a means of overcoming widely differing interpretations.

> *'. . . I think a lot of people make the document work and that's why you get so many interpretations of it.'*

> *'I wondered whether the piece of paper that we've got is inappropriate because . . . it's got no meaning . . . the meanings are vast, so it really is meaningless because it's open to interpretation.'*

Indeed, there is a danger of the documents being used tautologically. If at a particular stage in the programme a student is expected to be at level three, then performance tends to be rated level three. It is the self-fulfilling prophesy familiar to all educational researchers. Additionally, assessors can be misled by the definition of the level in relation to the task to be performed and thus be confused as to which is actually the appropriate box to tick:

> *'. . . I think everyone finds them quite hard to know, the wording of the assessment is quite hard and people always have trouble knowing which box to put you in, and the boxes don't run on brilliantly, and so it might seem that you should be in box one [when in fact the student should be achieving box three at that stage of the course].'*

The kind of judgements which assessors have to make are illustrated by Figures 3–5.

Item: **Deviation from the normal**			
Level 1	**Level 2**	**Level 3**	**Level 4**
Can participate with instructions to assist in abnormal situations	With assistance recognises deviation from normal and provides appropriate care under supervision	Is aware of the potential effects of abnormality in midwifery and can initiate appropriate action	Able to interpret and undertake care prescribed by registered medical practitioner where appropriate

Figure 3: Performance criteria

Level 1	Level 2	Level 3	Level 4	Level 5
Exposure	Participation	Identification	Internalisation	Dissemination

Figure 4: An adaptation of Steinaker and Bell's Taxonomy (Steinaker and Bell, 1979)

Standard A	Standard B	Standard C
The student is beginning to relate knowledge and skills to practice but requires constant aid and supervision	The student performs with minimal supervision, can explain actions and modify practice utilising theoretical knowledge	The student can manage and evaluate practice effectively and justify own planning and decision-making

Figure 5: A standards of achievement model

Our data suggest some fundamental problems especially with the first of these examples. For many, the categories within each box did not always reflect progression as it is actually experienced and expressed by the student on practice placement. In other words, for the assessor and student, the first level of a particular scheme does not necessarily represent a level of activity which is less complex than higher levels.

Furthermore, in adopting an assessment framework which intends to demonstrate student development and progression, many institutions were struggling with the challenge of maintaining a sense of continuity between levels of achievement. Progression through a series of predetermined levels implies an accumulation of experience and skills with each learning experience and assessment event, building on the achievements of previous levels. For some institutions, information about previous experience did not flow easily between practice placements, with the result that it was the students who needed to take primary responsibility for maintaining continuity between their placements.

As the following student outlines, assessor interpretation in relation to the different levels of expectation of student attainment was a problem for some:

> *'. . . I brought this up with the school . . . what I found with the clinical objectives is that they're very ambiguous, they don't really give a level. Like for instance . . . on the first ward, one clinical objective would be, "To be able to measure and record a temperature" . . . Now one mentor or staff nurse might for instance say, "Well I've seen them take or record a temperature, I've checked it, it's right, it's correct, that's okay." Someone else might see it as the competency of taking a temperature and so you'd be asked about different areas of taking a temperature, the length of time a temperature would be taken, "Do you know the relevant research for taking a temperature? What things are you looking for? When would you worry about a temperature?" . . . When I was asking the school [they said] "Every mentor does go on a workshop and [is] told about what levels to go on to." But I've never found that . . .'*

It would seem that subjectivity and multiple interpretation are inevitable in assessment:

> *'. . . it all comes down to what you do on a one-to-one with somebody . . . it's an intensive task . . . it's something that ultimately comes down to a feeling you have about an individual because you spend so much time with them, and there are markers or indicators within their performance*

. . . certain social skills have to be present . . . after that it becomes a measure of whether or not to put into practice quite subjective components. I'm talking here about mental health, perhaps, rather than what I call the tricks of nursing, which are injections and some of the more practical procedures which are obviously good or bad, because they're observable, measurable . . . I have . . . no difficulties with those . . . it comes down to whether or not you . . . follow certain patterns of behaviour, like when do you give advice? When don't you give advice? . . . What kind of attitude did you adopt towards somebody? What was your approach? And it has to be something which is analysed afterwards . . . the process of assessing somebody's level of safety or competence or quality if you like, is through a pretty intensive, interactive process, trying to establish what they were trying to do, how they did it.'

In this view, what is overlooked in the so-called objective approach is the educational dimension that is founded upon interactive processes. It is through such interactive processes that the less tangible aspects of competence are determined and assessed.

'Attitudes. Hardest thing in the world to measure, it's practically impossible . . . you can have a feeling about attitudes . . . you assume from your social mores what's a good attitude to the patient . . . You can measure knowledge. You can measure skills. But the best psychologists around have looked at various tools to measure attitude and have been singularly unsuccessful. There are lots of things that you can use, but the fact that there's so many of them tells you that there's nothing [that] particularly works.'

This educator goes on to express her opinions on what is an appropriate form of educational assessment:

'You could tighten up the schedule, the actual assessment process till it becomes . . . so specific that there's no variation at all. But I don't think that's really feasible when you're educating professionals, because if you tighten them up so far, then there's no room for judgement in there . . . Now I don't think that's good educationally.'

The fully standardised approach to assess practice is counter-educational. Indeed, the principles of classification differ in each case. Standardisation proceeds by identifying units of behaviour that precisely fit the category box. That is to say, each unit of behaviour placed in a particular category should be identical to any other unit of behaviour in that category. However, when the categories are subject to confusions (for whatever reason) or to alternative viable interpretations, there will be a wide range of possible candidates for inclusion in the category. In these circumstances, it will not be possible to assure homogeneity.

The structure itself also inhibits the re-evaluation of these kinds of assessments because there will always be insufficient evidence either to support or to challenge the tick in the box. Two possibilities to overcome these inadequacies are:

- to increase the number of independent witnesses who come to an agreement as to a particular judgement
- to ensure the recording of an evidence base for assessment decisions that is sensitive to context rather than being highly pre-determined and structured.

These two alternatives will now be explored.

4.4 Witness reliability

As has been demonstrated by the assessment texts discussed so far, if there is a weak evidence base, the possibility for further study of the decisions taken and the criteria for those judgements is less open to external scrutiny.

For the assessment of practice, it is the judgement of the professional – in ticking a particular box or in making a particular interpretation – that is at the heart of assessment.

> *'Most of my colleagues will argue strongly that . . . in terms of practical assessment we have to accept the professional integrity and the professional judgement of the practitioner assessing. And I don't accept that. I work from the other extreme and say that because they are a competent practitioner does not make them a competent assessor.'*
>
> *(Board representative)*

The competence of the assessor to assess is different from the competence to practice as a practitioner. There are distinct types of judgement involved: the assessor's is about the student's capability to judge, make decisions and act in a given circumstance at a given stage of development in the professional role. The reliability of the witness can therefore be increased by appropriate professional development. Meanwhile:

> *'. . . I do have concerns about this [assessment skill] . . . when I'm talking to . . . staff at audits and . . . I'm asking: . . . "what is it you're assessing?" . . . and they often haven't really broken down these skills . . . they haven't really thought about the level of the learner and what their particular needs are . . . they talk about things like . . . what's the role of the designated nurse in relation to preliminary interview? What are they supposed to be doing? . . . What information are they gathering about the student at that particular time?'*

Triangulation

Even if appropriate professional development can be provided there are still likely to be variations in judgement. This issue, it can be argued, can be overcome by taking into account more than one perspective, a process of witness triangulation. The triangulation of views can be employed to draw out both commonalities and points of disagreement. In this way individual bias can be reduced. The range of perspectives that can be set alongside each other include:

- the assessor
- the student
- the co-assessor
- other clinical colleagues
- the educator acting in a clinical liaison role.

Student self-assessment

In line with the Board's requirement for contributions to the assessment process, students are called upon to contribute to assessment texts. In the texts we studied, the minimum requirement consisted of the student's signature to witness the discussion that had taken place with the assessor at the initial, intermediate and final interviews. It also indicated that there had been an opportunity for the student to respond to the assessor's written comments with their own. A greater degree of self-assessment was encouraged in the type of text illustrated in Figure 6, where the student contributed their own judgement to each assessment item. While not

overcoming the problems so far discussed, it does at least offer self-assessment and the potential for the student to challenge a particular judgement.

Performance criteria

Performs a post natal examination, explains the significance of the findings to the midwife, gives correct advice to the mother in relation to:

S = student
M = midwife

Intermediate interview (formative) achieved/not achieved

Final interview (summative) achieved/not achieved

	S	M	S	M	S	M	S	M
signed								

breasts – prevention of nipple damage, suppression of lactation

abdomen – involution of the uterus, abdominal tone

perineum – healing, hygiene

lochia – changes

legs – oedema, tenderness

Competency achieved:

Signature: .....

Date: .....

Figure 6: Midwifery assessment schedule

In this example, an agreement between assessor and student defines whether the 'competency' has or has not been met. There is the potential for greater triangulation of views; nevertheless, once it is signed, there is no further evidence available for an independent examiner. The validity of the assessment is thus still dependent upon the credibility of accredited witnesses.

The intermediate and final assessments offer the possibility of facilitating diagnostic development and identifying progression within overall formative assessment rationales. However, it would be misleading to regard the one-off intermediate assessment as being 'formative' in the fuller sense of implying a process of continuous assessment and feedback; it simply offers an intermediate step towards the final summative assessment during the final interview.

Once again, considerable dependence is placed upon the quality of staff development for the purposes of assessment, and upon the staff-student assessment relationships. Theoretically, if it can be confidently maintained that each assessor is interpreting criteria in the same way, and providing high-quality feedback via a high-quality consultation process, then it could be accepted that the tick in the box, or the signed affirmation that a particular competency has been achieved, actually signifies what it claims to. However, if, as the data outlines, there is considerable variation of practice, multiple interpretations of criteria and limitations on professional development for the assessor and mentoring roles, then consistency of quality cannot be assured. It is not only that consistency may vary between assessors, but also according to circumstance with the same assessor:

'. . . my last student, it was fine. I worked with her a lot and I actually saw her getting better so I felt I could write a fair assessment on her. But the student I've got now, I've worked with her three times, four times, and I still have to write an assessment on her. But when I asked her whether she'd worked with anybody else in particular, she hadn't, so I couldn't even go to them and say, "How's she doing? Is she improving?" whatever, "What does she need?" . . . in the first talk with her, about what I expected of her and what she hoped to gain, and we went through the things that she had to do, I did that. But like I say, I'm going to have to write another assessment on her and I don't know much about her and how she's progressed. So that's difficult.'

Very little triangulation of assessment is required by the formats of documentation discussed so far; indeed, it would be difficult to implement in the practical circumstances that prevail. This creates potential obstacles for monitoring. Furthermore, there is no independent evidence base on which issues could be resolved in the case of an assessment being contested. All educators, of course, have some background knowledge of their students, form impressions and listen to the views of others; consequently they are often aware of the difficulties associated with some assessment texts:

'. . . we get these assessment forms back of course here in the college, and we discuss them and we look at the issues raised by them and then we try and iron out difficulties, whether that be the student contending what was written on the form or the staff on the ward contending what they've written on a form. And that sometimes will clarify issues . . . if there are issues it's normally related either to professional behaviour or communication skills on the ward . . . it's normally because . . . people have different perceptions of . . . how effective a first year can be, for instance in dealing with a bereaved relative, and so those are issues that we have to constantly revisit.'

Unless the evidence actually provides a detailed record of 'what happened', judgements remain susceptible to bias, misinterpretations, misunderstandings. These issues point not only to the complexity of the skills involved in assessment, it is also a matter of ensuring the appropriate assessment texts are created. Assessment is not simply a matter of exercising unambiguous judgement in relation to ticking a particular box. A considerable degree of reflection, analysis and dialogue needs to take place before common agreements can emerge as the basis for individual assessments. The philosophy, the principles, the procedures and the appropriate structures must exist in order to support an effective assessment process.

4.5 Increasing the evidence base

The research showed that participating institutions do generate evidence beyond the tick and the witnessing signature in one or more of the following ways:

- through a record of formal diagnostic interviews
- through a 'discussion statement' that cites an evidence base
- through learning contracts.

An evidence base can be used for a multiplicity of educational purposes. It can, for instance, start to integrate theory with practice as the assessment text encompasses the potential for research-based projects and assignments of various kinds.

Three formal interviews are normally planned during each practice placement, the first two are diagnostic, the final is summative. They act as a minimum requirement for discussion during a process of continuous assessment. These interviews may be used in conjunction with tightly framed assessment formats or with more open assessment formats.

The assessment document may, for example, specify that the preliminary interview is to take place in the first week of the placement with the object of including:

- a discussion of the personal objectives of the student
- the learning opportunities available during the placement period
- a discussion of progress to date towards achieving the specified levels.

Typically student and assessor are required to sign that these have taken place. As outlined in the previous section on triangulation, the practice involved in recording these discussions varies. A blank page is sometimes provided, in some cases with only general advice as to what should take place, or with the opportunity to record in summary form the agreed objectives/agenda for the practice placement. The notes and guidelines that may accompany assessment schedules may more precisely specify the questions to be addressed in the interview. The assessment document for the intermediate interview may similarly include space to record progress to date. At its minimum this may involve no more than pencilling in the ticks in the tick-box format. At its maximum, however, it involves a detailed open-ended discussion. A typical example of such a format for the intermediate interview is shown in Figure 7.

Placement mid-way progress review

Name of Student .....

Placement area .....

Start date .....

1. Identify problems in meeting learning objectives
2. Describe modifications to be made to the preliminary learning plan to overcome the identified problems:
3. Check your level of development against the expected levels in the assessment document
4. Identify areas requiring further help
5. General comments:
   a) Link tutor
   b) Student
   c) Mentor/Assessor

Signature and date:

Link teacher .....

Assessor .....

Student .....

Figure 7: Placement review document

The space given to record the results of the interviews varies from little more than a third of an A4 page to a whole page. At their minimum, formative interviews may be regarded as a record of aspiration and summative interviews as statements of overall achievement, rather

than constituting an evidence base of learning and accomplishment. In the example given in Figure 7, the opportunity for an independent evidence base which can be used for purposes of re-assessment is not provided. The external reader of the document would have to accept the judgements of the accredited witnesses; the evidence is still insufficient to be able to challenge the judgements. There is no evidence base to challenge any of the judgements made either by the assessor or by the student. Only if a member of staff testifies that the student is being too hard in their judgement can a challenge be accepted. But who is actually right? What evidence would be required to make such a judgement?

Discussion statements and the citation of evidence

An approach which begins to break down the listing of categories to ticks (supported by overall comment) is one where broad statements are provided as a basis for which evidence of achievement must be supplied. One example of this approach for diploma of higher education nursing student practice placements used broad statements referred to as 'stems', under which were suggested possible activities:

> *'The nurse assists the client, as an individual or in partnership with the family, with daily living skills and activities.'*
>
> This then is supplemented with a list of sub-statements:
>
> - *maintaining high standards of nursing care*
> - *assisting with the activities of living to promote self-care and reduce dependence*
> - *[others are listed].'*

Instructions are given in the student profile document as to how to proceed. A series of interviews is required where 'the learning needs and expected learning outcomes will be discussed and mutually agreed'. Completion of the document requires all experience gained and teaching given during the practice placement to be recorded in the appropriate section. The approach allows for more detailed evidence to be recorded than in the previous examples.

The approach is worth exploring in further detail because it gives an insight into the increased demands it makes upon the assessing processes. In the approved institution where this is operated, it is seen as an interim step towards a more open-ended process of discussion and negotiation. The idea, as the speaker below indicates, is to provide a general area for discussion with students which staff can develop in relation to experience:

> *'What we've got to get them to think about is – if we said this is an important area that we want them to assess, then they've got to find some experience that makes that live, and if we dictate it, what they'll do is try and do what we want as opposed to think about the area. What we want [is for] them to . . . find suitable experience and do suitable teaching for [the student].'*
>
> She develops this in relation to Rule 18a:
>
> *'. . . we were looking at the sort of areas I suppose that enliven Rule 18a but don't try to fragment it, because . . . sometimes . . . we try and break it down into it's bits and sometimes by doing that we actually lose what Rule 18a is about, which says that it should be all sorts of skills, developing a multitude of areas . . . So we've got things like "the nurse will promote a partnership with the family and the rights of the child and*

will ensure that she or he's always treated with respect and the dignity is maintained", and we wanted them to actually say, well what does that mean? What does that mean I have to teach? What does that mean I want them to assess? . . . [this time we've specified areas] but what we'd hope to do eventually is take all that out and just leave the gap.'

This type of assessment text moves away from a highly standardised format, and the evidence cited reflects the true contexts and experiences of the student. In addition, evidence of teaching undertaken is recorded.

The further developments required to facilitate this approach clearly depend upon the quality of professional development that can be achieved. There are demands upon the educational assessment expertise of staff which are not currently possessed but can be developed over time and with the appropriate structures in place.

The learning contract

Another approach offering a more developed strategy which moves towards tackling some of the inadequacies of the texts previously explored is the learning contract. Page one of an example contract asked three basic open-ended questions spaced out over the page:

- What have I achieved to date that is relevant to this module?
- What do I need to achieve during this module?
- What did I achieve during this module?

Subsequent pages of the document asked students to detail objectives, describe the resources and strategies they had used, and to include evidence for the reflection they had undertaken.

The contract was set out on A4 pages, the blank areas to be filled in by the student and validated by an assigned member of staff. The space available for the student was sufficient to allow the development of an essay. Completed examples showed the inclusion of descriptions of practices and experiences, supported by the referencing of relevant literature. As a result, the final product was very close to being a research-based assignment. There was a considerable body of evidence provided as to what exactly a student accomplished, together with integrated understanding of the knowledge informing that practice.

This different documentary format implies different kinds of skills appropriate to the assessment role. Indeed it was the case that at the approved institution from which this example was drawn, assessors were prepared and actively supported by a network of lecturer practitioners. The nature of the lecturer-practitioner role, based as it was in clinical settings, differed to that of an educator performing a clinical liaison role, located predominantly in the approved institution setting.

Assessment texts which captured the multi-dimensional nature of practice within a strong evidence base were valued by educators in approved institutions that were experimenting with learning contract approaches:

'I wonder whether it would be more beneficial if we just gave a blank sheet of paper to the staff nurse and said tell us whether this person's a competent nurse . . . I think that . . . pieces of prose freely given looking at positives and negatives would probably give you more of a picture of competence than something broken down into areas which are open to interpretation and rather vague . . .'

(educator)

This kind of thinking suggests a move towards a method of assessment which starts to address the issue of assessing theory and practice as an integral whole in the manner implied in the UKCC interpretive principles.

4.6 Towards the integration of theory and practice in the assessment of nursing competence

Theory and practice are often referred to as if they were in opposition with each other, the theory separated from and valued differently from practice. In an educative perspective, however, this is not the case; rather, the relation between theory and practice is one of mutuality and interdependence. While clearly not identical to each other, they can be regarded like the two faces of the same coin. To what extent, then, can the evidence base drawn from practice be used for further educative purposes, including the development of theory derived from practice.

Compared to texts used for the assessment of practice, those used for assessing theory provided a wider range of evidence and were more loosely framed. One educator summed up the general trend, as follows:

> *'I think very much clinical assessment is still . . . focusing on competencies and therefore what it assesses is restricted, it's constrained . . . However we do have the other side of the equation and that is the theoretical assessment schedules within the course which the college manages, in that they certainly . . . give the student opportunity in a variety of ways to demonstrate that they are developing the skills of analysis and synthesis.'*

The tendency for assessment strategies in practice areas to constrain what can count as competence in order to meet the demand for increased standardisation has already been discussed. In contrast, the wider range of evidence which can be generated from strategies for assessing theory suggests the potential for greater incorporation of practical experience within theoretical texts. In the next section, we explore a range of examples of ways of assessing theory in terms of their sensitivity to issues of practice and the extent to which it is possible to incorporate those issues into a broad theoretical framework.

The range of methods employed

The range of methods used for the assessment of theory include the following:

- literature searches
- case studies
- care plans
- neighbourhood studies
- poster displays
- personal journals/learning diaries
- critical incident analysis
- research proposals
- seen written examinations
- unseen written examinations.

Each method in this list has the potential to contribute either formatively or summatively to the overall assessment process. Ways in which each method is used varies from institution to institution. For example, one approved institution may use neighbourhood studies

only as a means of formative assessment, whereas in another institution this would be a summative piece of work. There are, however, some methods which are more usually assigned to one particular type of assessment. Personal journals and poster displays, for example, are more likely to form part of the students formative assessment, whereas seen and unseen written examinations are more likely to be used summatively.

Literature searches

Literature searches are often an integral part of other types of assignment. Typically the student is required to explore the available literature on a given subject and give a written account of the important issues and debates embedded in the body of literature. Literature searching can be purely an academic exercise. It can, however, be used as part of a problem-solving exercise where students are required, for instance, to explore the literature relevant to a problem they have experienced in practice. In this case, students give an account, not only of the literature, but the way in which it informs the area of practice in question, and in this way start to bring theory and practice together.

Case studies

Case studies provide students with the opportunity to carry out an in-depth study on one particular client/patient in their care. Typically case studies are constructed from the student's actual experience of a client over a period of time; hence, although students might be expected to draw on relevant theory to inform the case, the essential material often comes from the student's direct observation as well as historical documentary evidence.

Care plans

Assignments based on the construction of care plans not only require the student to use observational and documentary evidence in assessing their client, but also require the student to reflect on how that client's needs might be met and kept under continual review. Students might be expected to construct a care plan from scratch, critically evaluate an on-going and pre-existing care plan, or develop part of a care plan. A student in the early part of their course, for example, might only have to write about how they have contributed to a client's assessment. Most assignments based on care plans are constructed around the student's own actual experience of a client on practice placement and, like case studies, draw on relevant theory.

Neighbourhood studies and community studies

These typically require students to explore and describe in detail the characteristics and available resources in a given locality. They may be based on the needs of one particular client or a specific client group. Sometimes these studies are carried out as a group project and in such cases are more likely to be used formatively.

Poster displays

Like neighbourhood studies, poster displays of project work are often carried out collaboratively in groups. They can reflect project work which is abstract/academic and highly theorised, or, in contrast, they can reflect work which has been focused on practice and student experience.

Personal journals and learning diaries

Personal journals and learning diaries typically require students to record their reflections on their experience throughout the programme and draw heavily on the student's experience of practice. They may require students to consider personal learning objectives. Journals and diaries can be either confidential to the student, open to scrutiny by peers and teachers, or a mixture of both.

Critical incident analysis

Although critical incident analysis can be used as a verbal learning tool in clinical areas and classrooms, it is also used for the focus of written assignments. Critical incident analysis tends to focus on a particular student experience which may be part of everyday practice or it may be unusual in some way. Students are usually required to show a broad understanding of antecedent, contextual and theoretic issues in written discussion of the incident chosen. Critical incident analysis therefore usually has high potential for assessing the application of theory to practical problems.

Research proposals

Where students are required to produce a research proposal as part of their assessment, the extent to which the activity draws on students' own experience of practice is dependent to some extent on the way in which research activity is defined and understood within the approved institution. For example, where research is experienced as a means of enquiring into practical problems which students have encountered through their course, then its integrating potential will be high. Where it is taught and experienced at a greater distance from the rest of the curriculum, then its integrating potential will be lower.

Written examinations

The extent to which examinations are able to reflect students' ability to contextualise abstract theory and theorise about practical issues and experience depends both on the style of questioning and on the opportunity they provide for student reflection. Unseen examinations offer less opportunity for reflection than seen papers, and questions which focus on the range of considerations which are needed for a particular client are more likely to draw on the student's practical experience than questions which focus more on theoretical concepts.

Theoretical assessment

Although most of these methods of assessment have the potential to include student practical experience, assessment judgements were almost exclusively the domain of teachers in cases of summative assessment, and occasionally included student peers where assessments were used formatively. We found no examples of practitioner involvement in the assessment of theory even where assignments drew heavily on practice placement experience.

This chapter has considered a range of what we might now call 'theoretical assessment', that is, assessment with the potential for integrating knowledge and understanding learnt outside the practice situation with students' own experiences of practice. It is the contention here that this integrating function should be a high priority when strategies are developed for the assessment of theory. A summary of the mechanisms and procedures for collecting evidence that emerged from the research is included at Appendix I.

5.1 Introduction

The intended aims of practice placements in terms of learning and assessment events include:

- providing appropriate learning experiences
- ensuring that students are progressing towards and achieving 'competence'
- contributing to the integration of theory and practice
- providing formative feedback on students' progress towards achieving competence
- opening the horizons of the students towards future developments in the profession
- compiling documentary evidence to support summative judgements made regarding the students' levels of achievement.

Everyday work demands provide the context within which learning and assessment take place. The processes of education and clinical practice are not mutually exclusive. For the intentions of reflective practice to be realised, an appropriately structured environment must form its context. That environment must be capable of responding to needs and modifying its own structures to meet those needs. This includes making sufficient staff time available for learning and assessment events, professional preparation, personal commitment and liaison roles. The quality of elements such as these underpin the quality of assessment and learning events.

5.2 Contextual issues

Occupational cultures form the context to everyday practice. They translate formal concepts into everyday occupational ways of categorising and constructing meaning as the basis for action. When referring to assessment, students and staff talk about 'feedback', 'discussion' and to a lesser extent, 'reflection', rather than 'formative activities'; and about 'doing the assessment' and 'filling in' documentation, forms or reports rather than 'summative assessment'. The formal concepts are interpreted into the language of everyday activities. The language of doing takes precedence over the language of academic analysis. It is what Schutz (1976) referred to as the primacy of the pragmatic attitude pervading everyday affairs. In the pragmatic attitude the aim is to carry out a particular task 'for all practical purposes'. Placing a tick in the appropriate box, for all practical purposes, signifies the completion of an assessment task. In the pragmatic attitude this task is to be acquitted as quickly and as clearly as possible (Cicourel, 1964; Douglas, 1970). Typically this is the case; so if, for example, a student has completed two weeks in a clinical area without causing any problems, then, for all practical purposes, that student may be deemed to have successfully completed the practice placement experience. This may seem cynical; however:

> *'I think it's just like the old system really. If you go about things in the right way, if you're fairly pleasant to the staff and you get on on the ward, you're OK kind of thing. It's not a question of whether you're giving the right advice to women because they don't really know what you tell them . . . you're not assessed closely enough or supervised closely enough.'*

Or, in the context of pressure:

> *'My preceptor wasn't there, I wasn't working with her for a long time . . . I'd gone to the sister before and said, "Well, since my preceptor is not here can I have somebody else to do my interview?" and she said, "No you can't, you have to wait for the preceptor." When my preceptor came [back] she [said], "Well I want to find out how she's been working" and . . . she ended up saying, "You've got to go to the sister to have it done". So . . . it was the last day of my placement and in the end the sister . . . just took the book and she just ticked it. She just wrote a few comments. And some of the things she wrote, I never even did them.'*
>
> *(student)*

In contrast to this non-questioning attitude, the reflective attitude seeks to explore the background to or context of action. This inevitably raises issues with implications for the learning institution. The following four areas, which are discussed below, were the main ones raised by interviewees during the research project:

1. Liaison and continuity of support.
2. Course constraints:
   - short practice placements
   - timetable inflexibilities.
3. Workplace demands:
   - shifts
   - staff absence
   - competing practice placement priorities.
4. Individual commitment.

Liaison and continuity of support

Educators from approved institutions liaise with practitioners regarding the timing and nature of practice placements. Despite periodic educational audits of placement areas, circumstances can alter by the time a student arrives on practice placement due to changes such as in skill mix or in the specialty of client care provided. Consequently, there is a need, highlighted by the research, to maintain regular liaison between educators acting in link roles and practice placement areas. Where there is good liaison, problems of continuity of support are more easily sorted out. For instance, it becomes possible to ensure the early diagnosis of difficulties caused because a student's supervisor/assessor is often elsewhere when the student is in the clinical area. Research data show that where placement area staff receive sufficient information about the forthcoming practice placement, and in good time, these problems are dealt with satisfactorily. The liaison role is thus essential in ensuring that preparatory mechanisms are in place.

Programme constraints

Short practice placements, especially in the initial stages of programmes, and especially those of as little as two weeks' duration, are typically thought unrealistic for establishing and developing relationships through which formative assessment can occur and summative decisions can be reached. Students commented on their need for an initial settling-in period for any allocation to 'find their feet', become familiar with routines and start to develop relationships with colleagues. Students described these activities alone as taking approximately a fortnight, hence expectations of assessment activities occurring within such periods could be argued to be unrealistic:

'The other aspect of the whole thing that we've got to try and address . . . and again I think it's very difficult to do with the present course structure – is the length of time over which people are assessed. I mean it is . . . well the most positive way of putting it is a challenge to people to assess . . . students over two weeks. It's probably not very reliable . . . I think we need to look at when assessment occurs and the length of time that is allowed for that assessment and it may be that in some areas we don't do summative assessment, we do formative.'

(educator)

'They [students] have only spent two weeks in some places as a placement, well that's five working days and that's impossible. There's no ownership by the student nurse and there is no ownership of her mentor to look after her for five days, ten working days of which at best you might get seven working days together and on day number six she's got to assess that person and that's a nonsense . . . it makes continuous assessment a mockery. I mean you might as well almost, God forbid, go back to the old four ward-based assessments because all you're doing then is taking a snap-shot . . . if you've hardly got to know what that person's first name is and you are writing an assessment of that person which will give them their registration or not, the task is not only onerous, it becomes an impossibility.'

(clinical manager)

The brevity of practice placements not only affects commitment through a lack of a sense of value of the assessment, but also runs counter to the fundamental principles underlying continuous assessment. Many of these issues were already being tackled by approved institutions and remedial strategies set in motion. These included increasing practice placement length, removing some short placements from programmes or substituting formative activities for summative assessment.

Practice placement periods were also perceived to limit the extent to which a student could develop a holistic sense of care. One manager, for example, speaking about the care of elderly people commented that, because students had to leave the placement area for a study day each week at the approved institution, and because of limits on the length of their working day, they could not gain the full experience of care. They therefore missed important elements of the holistic nature of care and its management.

Workplace demands

The rhythm of everyday work in the practice placement area does not necessarily mesh smoothly with learning and assessment intentions. To ensure this mesh, the structure necessary to underpin assessment and learning experiences must be clearly and appropriately worked out. Unless this structure is compatible with the structures underpinning the work environment there are likely to be conflicts.

The main obstacles to the smooth functioning of the practice placement element of the programme experienced by students were:

- incompatible shifts due to holidays, night duty and requests for specific days off
- unpredictability due to sickness or changing workload/priorities (requiring assessors to forfeit working with their student for that shift to comply with care or management priorities).

These are illustrated in the following comments:

'Sometimes I've been luckier than some of them. I've managed to work with my mentors quite a lot but I haven't worked with either of them for the last three weeks, which out of an eight-week allocation is quite a lot. But prior to that I'd worked with them fairly frequently.'

(student)

'. . . it would be nice to . . . say that they do work very closely together [but] things like holidays, study days, students requesting off duty, sickness on the ward . . . other people being off, their mentor has to be in charge of the ward or whatever, can interfere with the process.'

(educator)

The extent to which responsibility was passed from the named assessor(s) to other members of staff when disruption of the student/assessor relationships occurred, varied. Where such back up systems worked or did not need to be activated too often, students felt supported. However, some students had more uncomfortable experiences where there was no 'safety net' of continuity:

'. . . you're passed from pillar to post really . . . you work with one person one day and another person another day . . . there doesn't seem to be the time . . . or you don't feel it's appropriate to say to somebody, "Would you mind sitting down and going through this [documentation] with me?" Especially when you don't really know them or they don't know what you want from it.'

The amount of time that students and assessors spend together was clearly felt to be important. When students felt 'passed from pillar to post', it was apparent that opportunities for developing relationships in which meaningful, quality assessment could occur were reduced. This is an example of the difficulty of combining care and assessment in a dynamic work context.

'[Clinical staff show] their commitment and motivation when I audit the wards – they spend their own spare time, practically in every instance . . . there'll be a current awareness file . . . things for the students' information . . . photostatted sheets out of books . . . Staff nurses . . . do this in their own [off-duty] time because their work time is taken up caring for patients, and they are spending their own work time supporting the students.'

(educator)

The issue of competing priorities in practice placement areas was raised by many individuals, but the extent of any problems varied. Some areas did not experience difficulty in accommodating client needs and students' learning and assessment needs. In others, the volume and increasingly involved nature of student assessment was placed in direct competition with the fluctuating demands of client care needs. It was noted that overall assessment demand within many practice placement areas had increased. Many nursing staff were, for instance, involved in assessing other health care personnel such as health care assistants and paramedics.

It was apparent that client need took priority. This stance was understood and unquestioned by practitioners, students and educators alike. However, the extent to which students' learning and assessment needs were marginalised and placed *in opposition to* client care needs, rather than working with the situation and utilising all available learning opportunities, was an issue for concern in some areas. The course of action appeared dependent upon the

motivation, morale and skills of the nursing and midwifery staff. Where staff felt supported and confident with their clinical and assessment skills, and had experience in each, they appeared more able to work with client care demands and meet student's learning and assessment needs. Where this was not the case, the quality of practice placements was affected:

> *'. . . some midwives will actually say to you, we're short staffed, we're busy, we've got two midwives on, we've got three students or four students or whatever, and my priority is the care that I have got to give and therefore . . . the students will just have to get into that. And OK that's the reality of practice today and in some ways the students have to learn to adapt to the realities of practice when these things are like that, that's part of their learning and provision of care, prioritising care; but it's not the ideal for a student who is new, trying to learn midwifery practice. And learning doesn't get planned, it happens ad hoc, which if it's persistently like that it's not a very good learning experience.'*
>
> *(educator)*

The increased demands of assessment and having to facilitate students on an ongoing basis was stressful to some staff, despite the overall enthusiasm. The effect was illustrated by a midwife who reported that a constant round of student supervision and assessment did not leave much space for her own professional development:

> *'. . . there's a group that's gone out, the second group, and we've tried to make sure that the first people don't have continuous assessment this time, so they get a break from that. Otherwise it means that everyday you go to work and you've always got a student, and that's a bit unfair. You need some time to look at your own practice.'*
>
> *(educator)*

Individual commitment

For the student, practice placements may be experienced as precious and unique; for the assessor, however, the student can be perceived as just another student from yet another programme. Commitment to assessment relationships affects their quality and hence the educational outcomes or benefits. From students' accounts we can learn what is important and valued by them in the assessor/student relationship. There were accounts of relationships which worked well and where students appreciated the benefits. Such accounts provided insight into the features (including mechanisms and procedures) required for effective relationships; they included continuity and support in facilitating the development of skills leading to independence (while providing appropriate levels of assistance), and giving the kinds of feedback that the students felt they needed. Equally, when there was communication breakdown and responsibilities went unacknowledged, the essential features of an effective system were noticeable by their absence. There is, of course, a sense in which:

> *'. . . you're going to learn, I think, wherever you are if you are willing to learn and you've got mental faculties . . . but it's so helpful if you've got a supportive network around you and people who are encouraging you rather than just leaving you to . . . discover things for yourself.'*
>
> *(student)*

Being able to watch others at work and learn from observation is important; however, this in itself was felt not to be enough:

'. . . although it's good to work with other people and see how they are doing things, I don't feel like I've had anybody to sort of fix to, or have a relationship with, that I can, you know, sort of confide in really, which is a pity.'

There is a close relationship between good practice and educational processes:

'. . . the people I [look to] as role models also seem to turn out to be the best teachers. They enjoy teaching and they'll ask if you want to go over anything . . . they'll get you doing the practical . . . like doing vaginal examinations and asking you what you're finding, and making you apply what you're finding . . . "What does this tell you? What does that tell you?" Whereas some of the others will let you sit there, let you do the observations like blood pressure and pulse all afternoon. They'll do the vaginal examinations, you'll ask if you can do one and the answer will be, "No there's no need for you to do one." Or they'll let you do one but they won't discuss it with you which to me . . . there's no point doing it because it's very difficult to assess what you're feeling when you first start.'

The reflective capabilities, motivation and commitment of students as agents in their own learning, while vital, are not sufficient in coming to grips with professional action. The above student comments refer to their learning needs and psychological needs such as 'confidence building', someone to confide in and so on. However, a further, educational dimension is needed, so that each student is facilitated in making links between the practical application of knowledge and not left to 'discover things for yourself'. The educational processes, psychological support and assessment functions must all work together. This involves attempts to 'get inside' professional action for educational purposes. For this, dialogue with experienced professionals is essential. It requires time and commitment and must not be marginalised by shrinking resources, variable levels of commitment and competing priorities.

5.3 Assessment and learning events

There are two kinds of learning and assessment events. Professional action involves learning from experience, assessing courses of action and performance, and making judgements about outcomes. It is an ongoing, 'natural' part of nursing. Performance, on the other hand, involves doing something to demonstrate ability to someone else. It is separate from ongoing events. Assessment events can either be perceived as an additional burden or as part of the continuum to professionality. When the focus is on professionality rather than performance, student assessment and learning becomes integrated into daily professional activity.

From the viewpoint of the student, any activity which happens prior to an official, summative assessment decision can affect their perception of what is important in judgements about nursing or midwifery competence; that is, about what it means to be a professional. Meanings about learning and assessment are constructed in various parts of the practice placement experience, culminating in the transaction between student and assessor which takes place when assessment documentation is completed. Official, summative assessment decision-making is not a stand-alone occasion, but is embedded in the composite assessment 'event' that runs through time and continuously shapes both the assessor's judgement of the student and the student's values about and attitudes towards particular nursing or midwifery practices.

The composite event can be broken down into five aspects which will be discussed below:

1. Tacit or hidden aspects of learning and assessment.
2. Formal formative relationships for assessment.
3. Summative assessment decisions.
4. Self-assessment.
5. Pass and fail.

Tacit or hidden aspects of learning and assessment

Learning takes place all the time. As well as the intended processes and outcomes of a particular learning environment, some learning takes place which is not openly expressed, nor necessarily intended. It is the kind of learning which occurs when the newcomer begins to 'sus out' the rules of the social situation and learns the appropriate ways of presenting themself in formal and informal relationships in order to achieve their desired effect. In short, they have to develop a model of 'the way things work in real life'.

The models that students develop are the result of attempting to 'do the job' and build a nursing/midwifery theory. Although one of these activities is usually thought of as practical and the other as intellectual, each is in fact a mixture of both; it is not possible to do the job without a theory of some sort, nor is it possible to develop a satisfactory theory without doing the job.

In so far as there are some procedures and practices that occur 'universally' within nursing/midwifery as part of daily delivery of healthcare, there is a fair degree of unanimity about the need to ensure that students are capable of doing the job by successfully carrying them out. As students observe and work alongside qualified staff, they discover that, for example, explaining a procedure to a client, confirming a client's identity before administering a drug and ensuring client safety in the bathroom, are essential parts of doing the job. They learn these aspects of practice informally and intuitively, through observation and emulation of role models in clinical environments. Doing the job with respect to these things becomes second nature, the theory is embedded within them and rarely drawn out.

However, in addition to the agreement about some nursing/midwifery practices, others are in fact the idiosyncratic preferences of individuals and groups; they are based upon differing degrees of experience, knowledge, argument, critique, values and beliefs. During learning and assessment processes, students come face-to-face with the fact that professional practice contains such complexities. Sometimes they experience this as a surprise, sometimes a disappointment, often a challenge. Students begin to realise that they cannot always take for granted that the value-bases that inform particular choices are agreed within a uniform theory of nursing/midwifery. The student must quickly learn how to read the situations they meet on practice placement.

Ideals in practice

For some students, dilemmas were faced when having to interpret the 'idealised' theory of practice learnt in the classroom in the light of the experience of practice and resource limitations. As one student put it:

> *'The major disappointment I've found is – when you're in school obviously it's a Utopia they talk about, which is, I think, good, you've got to have set standards in what you want to do – [but] you blame yourself when you come to the real world and you've got staffing shortages, people being sick . . . you know what you've been taught, research, counselling*

skills . . . all these wonderful ideas of actually sitting down and talking to people. And when you come on the wards, you really have to give . . . like . . . second best.'

This student learnt to take account of two different views of nursing, a theoretical view and a clinical view. She experienced a polarity between the 'Utopian' theoretical view and the 'real' world of practice.

Educators were aware that students often faced this dichotomy in practice, and had to develop ways to reconcile both experiences:

'The criticism as far as we're concerned is that we're trying to emphasise nursing care whereas they'll turn round and say, "Well, you know what you're saying is unrealistic, they wouldn't possibly be able to do that in . . . the ward, it just wouldn't happen." And I think that's generally quite a criticism . . . What we actually try to say it, "Well it's an ideal situation, this is what you should be doing." What they're saying is, "There's no way, there just isn't the staff to do it".'

(educator)

Values and attitudes towards client care

Students encountered many different attitudes as qualified staff and peers went about their nursing and midwifery care. They spoke of being faced with attitudes that mirrored or conflicted with their own values in practice situations:

'She's the sort of midwife I would like to be. She doesn't rupture membranes and apply scalp electrodes unless there's a need for it. But the women are always given an option, everything is discussed with them, she always finds out what they want first and will always comply with their wishes as far as she can . . . Things like pain relief – you can have a big influence on that by the rapport you establish. I've seen Jennifer talk to women with first babies who haven't needed any pain relief at all, which to me is pretty impressive. Whereas with other midwives it's, "I think you need an epidural," just because it's easier for them, they don't have to give all the support . . . Some [midwives] will get in an epidural and wheel in a television so they don't have to talk to them. You just sit there and think, "Oh God, I don't want to be here".'

Good and bad role models were identified by students as they experienced working with different staff members during practice placements. Students appeared to engage in a process of sifting out the practices and styles they wanted to emulate, and those which they found uncomfortable working with, or pressurised into having to do because of their student status.

Building a knowledge base and rationale for practice

Developing practical experience and exploring the theoretical basis for practice is also part of students' learning when on practice placement. The following example of a staff nurse preparing for the administration of intravenous medication with a student demonstrates the kind of craft knowledge that is often provided as they work together:

'. . . when you put needles in, be careful not to push through there . . . these are designed so that you should be able to get the syringe in and draw it without losing the needle . . . it doesn't always work . . .'

'. . . then we have a single flush because we use the flush to check that the line is working . . . so we put a bit of drug in . . . and also to flush it between drugs, 'cos some drugs don't mix in the vein.'

Such teaching and learning is highly valuable, particularly when backed up with a rationale and up-to-date knowledge. Sometimes, however, problems occurred when students encountered practices which conflicted, or when the rationales provided by staff were inadequate. These caused confusion and did not facilitate students' learning and development:

'I've been on certain wards and been told about not to use a steret [alcohol skin wipe] for when you're taking bloods for a BM [measurement of blood glucose level], for instance, because it alters the reading. And yet you can be on the same ward with another nurse who says, yes you should use that for hygiene reasons. I mean I know what you should be doing because I've looked it up . . . I was getting so concerned about it I phoned up the diabetic liaison nurse and had a chat with her . . . that's the difficult bit I find, the continuity of knowledge that we're given isn't there.'

(student nurse)

'I've worked with some people who've told me to do one thing one way and I've been quite happy doing it and it seemed right, and you'll go and do a delivery with another midwife who'll ball you out . . . and she'll say, "No you shouldn't do it like that," then, "Whose shown you to do that?" I don't personally like to say, "So and so said I should do it like that," and they don't seem to take that into consideration . . . some midwives are very good and they say, "As long as you're doing it safely then it's fine, there's no problem." But some are very sort of into doing things their way.'

(student midwife)

Handling the tacit or hidden aspects of learning and assessments

Students must find ways of either resolving these conflicts, putting them 'on hold' or learning to live with them. It may be that students themselves have to seek to supply their own rationale and continuity. This places a great deal of responsibility on the student who is in any case in a vulnerable position as the one being assessed.

Going against the norms of a ward or of a colleague was one option, but this can, in turn, bring difficulties for the individual:

'I wonder if I ought to just do some reading and look at the procedures and then make up my own mind about what I should be doing. But that's probably a good way to alienate everybody at once.'

This student was clearly interested in developing her own understanding, but was nevertheless bothered by the probability of being shunned by staff because of her wish to base her practice on enquiry and research. Others less certain about their direction may be more easily deterred from educative activities when clinical staff discount 'book knowledge' and prefer their own 'folk knowledge'. Students may be faced with choosing between innovating, despite the probability of opposition, or 'making the best of the situation' through accepting that for assessment purposes it is necessary to carry out impression management:

'I will be more careful who I listen to and what conclusions I come to . . . if I am told by a particular member of staff to do this or do that . . . I will want a rationale for that.'

'We've all sort of found you just adapt to what the midwife wants and you console yourself with the fact that, "When I'm qualified I'll do it how I want to do it".'

In practice, however, the extent to which students exercise individuality depends upon the degree of match between their own values and those of their colleagues in particular clinical environments. To discover the latter, students have to engage in an ongoing monitoring of the variety and range of practices, procedures and theories they encounter, and arrive at interpretations of their own. In this way they learn to be competent in ways that fit with what is required of them by a range of people from a variety of clinical and classroom environments.

Part of successful participation in assessment requires an understanding of the 'rules'. It is also impossible to acquire those rules without at the same time acquiring some knowledge of values. One of the key things a summative assessment may assess is the extent to which a novice has internalised the rules and values of those assessing. In the course of their observation and work alongside colleagues who model behaviour and attitudes, students have to take account of the professional's expectations and values. What gets assessed on formal assessment occasions (i.e. the two or three occasions when mentors or supervisors sit down with a student to fill in their assessment schedule document) may be influenced by what students have learned informally about assessment while they have been doing things with or chatting to the staff. It may also depend upon the student's perception of what it is 'safe' to challenge; challenging the attitudes and work patterns of others involves personal risk.

Formal formative relationships for assessment

A successful formative relationship not only focuses on, but is also integral to, the processes of action, reflection and development inherent in work practices. Isolating instances of assessment is thus inappropriate. How then, is formative assessment as a formal requirement accomplished? A key procedure is the generation of feedback. This in itself depends upon some way of recording and analysing 'what happened' in order to think about 'how to improve, develop, change'. The kind of evidence base that is required to underpin formative assessment events is one that is responsive to processes and situations. It should provide evidence of reflection within the processes of practice as well as reflection on the processes of action at some later date.

Journals written by students provide one means of doing this. They are often built into programmes, either as personal records for the student, as documents open to inspection, or both. Their quality depends upon the extent to which students are inducted into strategies for observation and record-making, and the sustenance of motivation thereafter. There is a difference between a journal entry which merely notes the occurrence of an event and another which describes in detail: what, when, how and who was involved, what was said, what was considered in forming judgements and decisions about what to do, and what the outcomes were, together with critical commentary on what might be improved. The quality of a journal thus depends upon 'frameworks for seeing'. Individuals who are not skilled in a given area do not 'see' as much nor quite the same things as an individual who is an expert. Formative assessment is all about how students begin to internalise expert ways of seeing as a critical step towards making evaluations, decisions and carrying out actions. Continuous assessment means that occasions for such internalisation to take place are pervasive, not 'one-off'. In this case feedback becomes a part of general interaction:

'I don't usually set an appointment for that, but I think you're almost doing it on a daily basis without really thinking about it. You know a situation will occur on the ward . . . or they observe a situation and you put it back to them, "How would you handle it? How do you feel about

that?" Or "I think you did that really well, what do you think?" . . . I think it's more informal then. But yeah, there is opportunity to do it.'

(staff nurse)

'I get them to . . . try and keep a learning journal and then we can reflect on it, maybe on a day-to-day basis or maybe once a week.'

(staff nurse)

'I'd say most of it was on an informal basis. If you sit in the office and say, "Did I make a mess of that? Is that OK?" and they'll say, "Oh I think you shouldn't; perhaps it's a good idea to do it that way; and why don't you try it this way?" And sort of advice and prompting. Although you have your own primary nurse everybody takes you under their wing because you're a first year student.'

(student)

These approaches to feedback and reflection parallel the kind of learning that 'naturally' takes place in any socialisation process. For that reason it enables the student to internalise habits of reflection, analysis, evaluation. Nevertheless, the kinds of activity outlined in the previous extracts represent the features of a continuous approach to assessment which is still new, and remains alien, to many. The new is often interpreted in relation to the old, and this is understandable when recalling the lack of professional development received by some assessors. As a consequence, assessment can be perceived like the assessments of old, and treated in the same way:

'I think we've adjusted to it more, but I think the clinical staff find it difficult . . . I think she [the assessor] finds it quite difficult, the importance. [It] actually goes in front of the examining board and they have to pass it, whereas . . . there's still the old feeling that it's just a ward report and somebody looks at it and says "Oh pat you on the back." And the amount of time we actually spend . . . It's not "I'll take it home and bring it back," it's, "Sit down and let's do it for an hour," which is very difficult on the wards, especially if they're busy. Yesterday we sat down and we – I set down my objectives of what I wanted to do up here and it took us nearly two hours.'

(student midwife)

Continuous assessment is not a short cut. It demands substantial time, effort and understanding, carried out on a regular basis. Good continuous assessment is not guaranteed and constructive feedback is often difficult to come by:

'It doesn't happen very often that you do actually get very good constructive criticism. I've had it once or twice, but you tend to get more of the bland sort of comments most often, which I think probably is a problem.'

'I felt she was patronising me slightly by saying, "Oh you're very good at doing the paperwork aren't you," that sort of thing, and I was thinking, "I don't need that sort of feedback, it doesn't interest me".'

'I think sometimes people don't like to tell you that you're not very good, even if you ask them. I don't know if they think that you're going to burst into tears or get really offended and walk out, but as I say . . . I find I benefit from it as long as it's constructive criticism.'

The following midwifery student was asked whether she had received any good feedback:

> *'I can't say that I have! Is that good criticisms? I don't know. I think everywhere that I've been, because we're taught to ask, "How did you think I was doing that delivery?" or "How was I doing that post-natal check?" And they are just sort of, "You're fine, you're fine, you're doing OK" And that's the end of it. They [the assessors] are just not taught I don't think, they are just not supported enough to know what to say . . . or they just don't realise what the philosophy of the course is . . . reflective learning – they just don't seem to understand.'*

The following frank statement from a staff midwife illustrates what can be a real problem for assessors:

> *'I shy away from having to give criticism anyway. I'll always go to great lengths not to give criticism, so I'm not a very good assessor from that point of view as I'll always highlight the positive aspects and I'll tend . . . not to go into too many details if a student isn't doing terribly well in certain areas.'*
>
> *(staff midwife)*

It is not possible to compel formative relationships, rather they have to be grown through sharing good assessor practice during, for example, professional development meetings. Thus it is difficult for education staff to be certain about the overall quality of students' experiences whilst on practice placement. There is still very much the sense that the process is in transition and the quality of experience is thus necessarily variable:

> *'I think reflective practice and being critically reflective is something quite new in terms of the concepts taken on board by clinical midwives. Because, I think, one of the difficulties we've got is that we're educating these students towards diploma status, but they're working alongside midwives who have all been at certificate level and haven't been used to that way of thinking and working. And that's a difficulty, I think, that's big, personally. And of course we can't get all midwives to diploma status overnight. So there's a gap there, you know, between what we are asking the students to achieve and how to achieve it, and the way the midwives actually see it.'*
>
> *(educator)*

The time required to fulfil current assessment demands is significant, and students' assessment and learning needs are sometimes subordinate to client care demands. Consequently, taking up those opportunities which do exist depends on:

- the extent of assessor motivation
- the quality and quantity of appropriate professional development
- the conceptual framework, skills and confidence to work closely with students.

It is understandable in conditions of limited staff resources that students' assessment and learning needs can become marginalised by patient care priorities. It is also understandable that staff who have not been involved with extended forms of professional development will find it difficult to recognise and understand the importance of and need for formative strategies. Where such formative strategies are particularly lacking, students report that personal reflection and self-assessment become their main sources of progress:

'. . . you know yourself that you've progressed . . .'

'I mean, obviously, if it was something major, if you were practising dangerously or breaching confidentiality then other people would pick up on that. But the more intricacies that you know you're weak on and you need to develop, I mean really you're probably the best person in some respects to identify that sort of thing.'

(student)

However, such self-assessment cannot be a complete substitute for good formative assessment provided by staff:

'. . . because if you're completely lacking in some area you might be so lacking in it that you don't realise that it exists, and its importance . . . So I mean you do need outside input as well, definitely.'

(student)

Since formative assessment is closely allied to work processes, it's proper use facilitates the internalisation of reflective practice on the one hand, and contributes to summative assessment events on the other. However, formative activities can only do this if:

- they occur
- there is an appropriate evidence base to draw upon
- staff have received appropriate professional development
- staff are fully informed of the programme aims and intentions for the practice placement experience of the student.

Summative assessment decisions

The assessment of practice contributes significantly to the overall assessment strategy and summative decisions determine the status of professional registration. Consequently, the effectiveness and quality of summative assessment decisions is vital.

The issue of determining when summative decisions are made during the practice placement period is a difficult one due to the great variety of observation, judgement, discussion and reflection which may occur between students and members of staff throughout the practice placement. The making of summative decisions is not merely the completion of assessment documentation during the final assessment interview.

The importance attached to the three assessment 'interviews' varied in the study. In some assessment relationships the documents were used at regular intervals, more frequently than the three scheduled times, to check progress made towards achieving stated aims. In this instance the document is completed gradually as the standard is achieved, or, as areas of weakness are identified, planning takes place to meet those aims. The documentation thus acts as a constant source of reference. In this way, the foci of the three interviews become subsumed within a more continuous assessment process. This is in the spirit of the continuous assessment philosophy, where one intention is that there should be no division between student learning and assessment. The potential danger lies, however, in the three interviews becoming the focus of the assessment, with little or no formative activities occurring between these three isolated events.

The intention for continuity of assessment activity between formal assessing occasions needs to be explicit, as the following educator outlines:

'. . . we have a preliminary and intermediate and a final interview . . . but again we try to emphasise to the midwives and to the students that there should still be the discussion ongoing even between those interview times . . . to highlight the importance of talking to the student and formalising what you're saying . . . [the interviews are] for the purposes of identifying any weak areas for the student to work on . . . But also – I think in many ways this is more important – to pick out what the student's strengths are and to, you know, encourage her . . . Because I think students do much better if they're encouraged as well . . .'

However, even the minimum of three interviews cannot be guaranteed. They do not always occur as planned:

'I think what it's supposed to be is that you go on the ward and they introduce you, and then you get your interview after you've learnt say maybe about the ward . . . but I think because of the short staff you can never work with your mentor . . . in the end probably you won't have your second interview, intermediate interview until the last day, you have both of them [intermediate and final] at the same time. And at times you find you have other things that you would have liked to achieve, but because you never have the interviews, you don't.'

(student)

As a consequence, opportunities which could maximise learning on a practice placement are lost and weak areas of a student's performance may go undetected.

Adherence to the formal events neither guarantees the quality of decision-making nor its appropriateness to the development of learning. Nor does a completed document imply that the required activities have, or have not, taken place. The following comment is from a student at her intermediate stage:

'. . . I've worked with Doreen an awful lot so she knows exactly where I'm up to . . . we've talked about what I actually need, although we haven't actually filled the forms in. But that doesn't mean that we haven't done anything.'

Where students worked with other staff in addition to their assessor to provide continuity and overcome the kinds of practical disruptions to the assessment process previously discussed, there was a need for these staff to come together and pool their experiences relating to the student. Where this happened, students frequently expressed their satisfaction with the decision-making process, for example:

'. . . my experience on the whole has been pretty good in that area . . . they've made it clear to me that they are seeking the opinions of other staff about the way I'm working . . . you know that's happening and that's fine as far as I'm concerned.'

(student)

Many educators recognised that this was not always the case:

'. . . we've said that it's important for them to get the experience of other midwives apart from the one who is assigned as their assessor because of the variety of approaches and experience that's available in any area. Now ideally I would like to see those midwives linking up in terms of the experience they've had with that particular student. In reality I don't

think that is something that happens from my own sort of queries and questions about it in the clinical area and with the students.'

(educator)

Even when staff involved in working with the student do liaise regarding the assessment, it was a common feeling that the quality or depth of consultation was not always satisfactory:

'That's our meat and drink, these forms. But as regards to assessment in the clinical area it's word of mouth entirely. So if I'm away and I come back and I'm just going to finish off the final assessment with this student just leaving the area, I'll go around asking people who've worked with her. So . . . it's a bit basic really isn't it? . . . We don't test on how to do a VE or how to do a delivery. It's just a general, "Oh yes I've found her to be very hard working and very good".'

(assessor)

There was here a sense of assessment as a routine activity, not helped by this assessor's poor understanding of the intentions behind assessment. In her view, since nothing is 'tested' in a one-off situation or performance, then only character and general motivation formed the basis of the continuous assessment process.

In general, the most effective formally scheduled events allowed a triangulation of views, a sharing of experiences, the diagnosis necessary for forward planning. In particular they created the framework for the kind of internalisation of judgement that allows self-assessment to become the basis for future professional development.

Self-assessment

In one view, the activity of self-assessment was recognised as a challenging but essential part of the process of learning, development and taking responsibility:

'. . . it's amazing how students see themselves . . . they say, "I can't do that! Oh God this is really difficult!" But it's amazing what you get back and it's a great basis for discussion when a student rates themselves half way.'

(staff nurse)

'I found it intimidating the first time I did it, I think most people probably tend to underrate themselves.'

(student)

'I think it's got to be a two-way process . . . you don't always get true feedback from the student because they're afraid of what's going to happen. Even with continuous assessment there is this element of it being punitive, or potentially punitive, and I think that's very sad.'

(educator)

'. . . we talk about this endlessly . . . the need for the student to be involved in their own assessment, and if there are any areas that they need to develop . . . being involved in the documentation . . . the formulation of an action plan which the student's actually involved in . . . and then things go wrong and you realise, again it hasn't been done.'

(educator)

Essentially, self-assessment parallels formative assessment. It can be seen as the internalisation of the latter and is an essential ingredient of the development of professional judgement. From students' comments it was apparent that some staff were either unaware of

the need for a substantial element of student reflection and self-assessment, or that they applied out-of-date approaches to assessment and failed to consult students over their assessment decisions. Such assessors just went through the motions of talking about what they had written down, with little room for student negotiation:

> *'. . . the first two reports that I had, it was more or less a fait accompli . . . "This is what I've decided," and although we did discuss it – it was made clear that there weren't going to be major changes to what the primary nurse decided.'*
>
> *(student)*

This student went on to suggest that this non-negotiative approach had the potential advantage of raising student's awareness in the early stage of training where staff were in a better position to gauge students' practice because of their greater experience. If such relationships continue, how students then escape this 'dependency culture' remains as an issue.

Pass and fail

If asked what the key criterion for pass or failure is, most people – whether professionals or lay – resort to a statement that includes 'safety to practice'. At first sight this seems a clear criterion. Fuller reflection soon reveals its complexity.

A considerable amount of data has been collected about the assessment decisions made regarding weak students and whether these decisions of student success or failure were reliable. The data relating to non-continuous assessments were informative in providing a context of assessment issues through which the effectiveness of continuous assessment strategies could be considered. Assessment of competence, this report argues, refers to a developmental process where notions of self-reflective critique, dialogue and negotiation are integral. Failure, in this context, can be seen in terms of the absence of progress, or inability to progress, rather than a failure to meet a minimum.

Continuous assessment was welcomed as a means of promoting greater confidence in decision-making, particularly regarding weak students, because it offers a greater opportunity to judge the consistency of student performance over a wider range of situations and contexts than can one-off forms of assessment. Indeed, continuous assessment was seen as more appropriate to the flow and dynamics of the work situation than a one-off assessment could be. In addition, by reinforcing the responsibilities of clinical assessors, it was envisaged that greater confidence could be placed on their professional judgements. This rationale is clearly expressed in the following comment on the change to continuous assessment:

> *'. . . the likelihood of people failing may not necessarily be stronger, but the responsibility definitely rests with the . . . service side . . . more people are likely to fail as a consequence of poor clinical practice than poor educational practice because we've reduced the amount of educational tests to a minimum in an attempt to make them more purposeful and meaningful . . . But in the clinical area if they fail, it will be because a staff nurse has said they're not good enough, and . . . then that's it, that's their course finished, and that's . . . quite a dramatic event. Whereas, as it stands at the moment, they can fail three components of the course, three consecutive units, so they could fail a whole year and a bit and still take their finals.'*

Assessors require considerable skill and confidence to handle the assessment of weak students effectively; such situations were often experienced as great challenges both professionally and personally. Consequently, professional development and support are vital, particularly when assessors also have to adapt to demanding and sensitive issues combined with new approaches to assessment. Staff who received professional education under the previous system need re-skilling to feel confident to handle weak individuals amongst a new generation of students assessed on the principles of continuous assessment. Other practitioners who find themselves in assessing roles for which they received only limited assessor preparation can feel vulnerable carrying such a responsibility:

> *'If I find a student that is so bad and I don't feel as if I'm equal to be able to give her criticism because it would be unfair on her and unfair on me, then I will try and pass the buck upwards, that way.'*

The need for professional development to ensure understanding and action within new approaches to assessment was identified as essential for all staff involved in assessment activities. Some educators were aware that this was, unfortunately, not always the case, and that this could have serious repercussions on the detection and action taken on weak students:

> *'I mean you've got to have the knowledge base and the skills to say . . . someone's not competent. To do that you've got to know what you're talking about and their training might not have given [them that]. If you don't know, you might as well put a tick because if you put a 'no' and they challenge you . . .'*
>
> *'I don't think the clinical staff feel supported enough to, say, fail somebody on the clinical assessment.'*
>
> *(student)*

Where doubts about the quality of students are expressed (either formally or informally) the implications of them 'slipping through the net' to become registered practitioners can be grave. Users of health care must be assured that systems of professional education possess rigorous assessment procedures which do not allow unsatisfactory students to progress undetected.

Although it was clear that poor students were in a minority, the issue is still an important one. Any student who is either not progressing or failing to meet the required standard needs to be identified by assessment systems. Diagnostic activity must be carried out so that students have opportunities to improve. Not only does this reiterate the need for professional development and support for assessors, but it highlights the importance of assessment texts to provide structures for the production of an evidence base which can be reviewed and reflected on regularly. Development needs can be identified quickly, detailed action plans can be negotiated and detailed evaluations should result. If, despite remedial action, development does not occur and standards are not achieved, then failure decisions can be made fairly and on the basis of a fully documented evidence base.

6.1 The need for effective monitoring

Monitoring is the way that institutions, like individuals, learn, develop and adapt to changes. The structures, mechanisms and roles through which these activities are executed within approved institutions share the common purpose of bringing about a closer mesh between programme intentions and the structures, mechanisms and procedures employed in practice. However, the maturity of the assessment strategies, and of the monitoring and developing systems associated with them, varies considerably.

With the devolution of assessment from national to local level, approved institutions now carry the responsibility for monitoring, reviewing and evaluating the effectiveness of all aspects of the assessment process (ENB, 1990, p. 52). Examples of the kinds of mechanisms which have been developed to meet these responsibilities are:

- assessment/examination boards
- assessment/examination subgroups
- meetings/forums for assessors of practice
- programme management meetings
- end of practice placement/part/programme discussions/written reviews and comments
- the clinical liaison role of educational staff
- the educational audit of practice placements
- reports from external examiners
- agreed notes from students' reflective discussions.

The research found that the monitoring of local strategies on a national level occurred through links with Board education officers and the yearly submission of an annual report on assessment to the Board.

There was a perception that growing familiarity and confidence with assessment strategies has ironed out initial problems in some areas:

> *'. . . you even hear positive statements as well these days! So, yes . . . I think it has got easier. More and more people get to know the system, more and more people have used it because of the numbers of students going through wards, so certainly people are more familiar with the documents, more familiar with the expectations that are . . . required of them . . . and more sure of their role really; so, yes, it has improved. It has got better and the indicators for that are that they're becoming critical of performance perhaps . . . they're talking more positively about it in an informal sense and there are less cries for help. I mean they're pretty crude measures but . . . there is an improvement.'*

From further comments made by this educator and others, however, it was clear that becoming familiar with the system and getting used to the documents was insufficient. The need for active and effective monitoring throughout systems was recognised, particularly for new programmes:

'. . . it'll be interesting to look at the evaluations . . . we haven't really got enough experience of it yet to see what the difficulties of it are and what things are good about it . . . staff will have to look really across the evaluations to see . . . where we can make changes. I think there are a lot of challenges, clinically and theoretically to this course – and educationally.'

(educator)

The issue of the effectiveness of current strategies for monitoring assessment was raised in the data. Some parts of the assessment system were seen as more accessible to monitoring than others.

Written assessment

Written forms of assessment appeared to be most open to scrutiny in terms of opportunities and activities for monitoring their quality, validity and reliability. Double marking by assessors, marking guidelines/criteria, and detailed comments sheets made decision-making for written assessments explicit during regular assessment board meetings.

Assessment of practice

In comparison with written forms of assessment, the monitoring of assessments of practice appeared to be less accessible and therefore considerably weaker and less effective. The project data raised three main issues.

1. The ongoing, continuous process was a difficult and time-consuming activity which many educators did not, or could not, participate in and monitor (to any great extent) as part of their clinical liaison role. Consequently, monitoring predominantly occurred after the assessment, using completed documentation for review during exam board meetings, and, in some instances, during meetings between educators and students. Only a small number of educators spoke of being able to attend assessment decision-making occasions with assessors and students on a regular basis.

2. Approaches to the assessment of practice and the formats for the majority of documentation used in the approved institutions in the study did not facilitate scrutiny of:

   - the quality of the assessment processes culminating in assessment decisions
   - details of the students performance, progress and development.

   This was because the recording of assessment decisions relied heavily on the assessor as 'accredited witness' rather than the production and recording of an evidence base amenable to independent assessment.

   As a result, it would be possible for completed documentation to conceal the quality of the assessment processes, their validity and reliability and also the quality of student performances within two sets of identical ticks and similar comments for two entirely contrasting practice placements. On the one hand, an ongoing, well-developed assessment relationship between student and assessor where constant dialogue, feedback, questioning and reflection were prominent features could be reduced to a series of ticks and brief written comments because of the requirements of the assessment documentation. On the other, a poorly developed assessing relationship where there had been little continuity, discussion or reflection between assessor and student could give rise to an identical set of ticks and similar brief written comments.

3. The success of the other forms of monitoring varied considerably in their ability to:
   - highlight and explore assessment issues
   - act on the issues raised as a basis for development.

The evidence base for assessment should aid the process of monitoring. Assessment decisions and the criteria on which they are made must be explicit and open to scrutiny via monitoring strategies; the quality of the assessment process needs to be open to similar scrutiny. The task of the monitoring system is to reveal the issues.

6.2 Revealing the issues

This section describes the experience of a group of midwifery students attempting to air their concerns about variations in the quality of practice assessments as a basis for future action. It represents many of the conflicting issues which other staff and students experienced in different contexts.

In the absence of quality assessment on some practice placements, students found themselves performing a mediating role of translating the assessment discourses, informing poorly prepared mentors how to interpret assessment guidelines and complete documentation. This put students in a very difficult position. One student described her experiences:

> *'Well I think it makes a mockery of the assessment really, because . . . they say, "What do I write here? What do you want me to put here?" I mean it's not really how they should be done, yet I don't think it's up to us to . . . correct it . . . [the assessor] said "I want to write it like this, I don't know how to write it in this educational jargon" . . . but it's not up to me to say "You can't write that, you must write this" . . . I think they need so much support in knowing what to write. We've been doing this for a year now and they are still asking, "What do you want me to do? What do I do? Do I tick or do I write A, B or C?" It's . . . not very good really when it's continuous assessment.'*

The above student's assessor voiced some of the difficulty she experienced knowing what was required of her due to the change in clinical assessments which now required a more in-depth approach:

> *'. . . if I could just put, "[She] has been an excellent student and has achieved all her aims and outcomes," that would have done for me, but it won't for [the education staff] – or will it?'*

Similarly, a midwife educator pointed out:

> *'And you sometimes find the situation where the students are actually explaining their assessment package to the midwife who has got the responsibility for it. You know I have difficulty with that one!'*

Many students were unhappy to lead their assessments where assessors lacked the required skills because they regarded it, quite rightly, as inappropriate to their status as learners. However, tackling the situation was problematic. Some students recognised the sensitivity required to change assessors' perceptions of the assessment. Others spoke of the difficulty of being empowered enough to challenge the situation 'face-to-face' because of the potential threat and personal consequences that may result:

'I mean in school we're forever being told to question and challenge, but it's easier said than done. You get in the clinical area and it's like the old reports, you think, "I'd better not say anything because I don't want to blot my copy book, I want to keep in here and be friends with people and not rock the boat too much." So what do you do? I feel like I want to be more assertive, and turn round and say, "I don't agree with this, or this isn't right," or whatever, but I don't think I can.'

Some students assisted poorly prepared assessors feeling that it was partly their responsibility, but found the ambiguities of this role difficult to reconcile:

'. . . if you've got students in an area then . . . you should be familiar with the assessment forms. Perhaps it's the fault of school as well, I mean they do have a link teacher but I don't know how much that link teacher is used . . . I think it's everybody's responsibility. I mean, I don't think it's not my responsibility, obviously. In a way I should be assertive and say, "I want to achieve so and so today" . . . it's probably a fault on my part as well.'

Students were not always happy tackling the situation via more formal structures. Some felt they did not want to be seen as a 'trouble makers' and also spoke of not wanting to hurt the feeling of others by 'going public'. One student gave an example of a typical comment on her assessment which read, "Overall working with S has been very good," but she hesitated to take up the issue of the inadequacy of her assessment:

'I don't want to put it on record, 'cos she's excellent at teaching and everything and she's been a really good supervisor/assessor, well supervisor, but maybe she's not used to the assessment forms or to writing in the sort of terms that educationalists expect now.'

Despite the rhetoric about open forums for effective monitoring of assessment activities, individual experiences were not always favourable. For some, the personal and professional skills and confidence required to engage in such activity effectively did not come easy. Likewise the creation of a non-threatening atmosphere in which discussion could take place was not always attained. In addition to the need to feel secure and comfortable during monitoring and review sessions, feeling that your comments are valued and will be acted on wherever appropriate and possible was also raised as an issue. The midwifery students discussed their frustration when asked to give feedback on their clinical assessment:

'Well I said to them [tutors] they [the assessments] are not taken seriously enough and that they're just on an ad hoc *basis. But it's not what they want to hear really. They want to hear that you've had appointments with your clinical supervisor and that it's been taken very seriously, but they're just not . . . – it's a problem.'*

'. . . comments that we've made, quite constructive, we haven't, you know, rocked the boat or anything . . . and it's disappointing to see that eighteen months on, the same mistakes are being repeated and groups are making exactly the same suggestions and complaints that we made, which is a shame really.'

An educator on this programme was aware of the difficulties faced by these students, and that as a consequence little action resulted:

'Whenever students come with problems I will say to them, "What have you done about it? Have you actually addressed it in any way? Have you actually talked it through?" Now that's where the difficulty comes in . . . there are many things that prevent students from being open and honest about how they feel. I mean sometimes I think they don't always have the skills in terms of expressing it in a way that will be received well with clinical staff. And I think clinical staff are also very threatened sometimes. But when it relates to something that's happened in the clinical area they tend not to do anything about it because their comments will be, "Well it's not going to change anything if we do, it'll only make my situation worse . . . I will be isolated out as a 'problem student' in inverted commas, and then I might be treated differently." So rather than deal with it they tend to accept it, not do anything about it and put up with it, which has implications for their learning . . . And another thing is they talk about the grapevine, you know, "If I do anything about it, say anything, it will be round the unit in no time," which is quite sad really, isn't it.'

Some students had become resigned to the 'quiet life' approach, no longer feeling willing or able to take further action on the issue, when previous attempts had been unsuccessful:

'I think it is difficult to criticise yourself and if somebody's quite willing to write, "A nice person. Settled into the ward well," it's easier to leave it at that really. It's more challenging if you have to sort of say, "Where are my weaknesses? Record them so that I know them to progress." So I think it does put more responsibility onto the student.'

Despite the educator's informal understanding of the situation, the problem remained formally unacknowledged; action was not taken to overcome the stalemate that had been reached. Both formal and more direct personal approaches were viewed as either too uncomfortable, too threatening or ineffectual. This appeared to be strongly linked to the lack of dialogue and debate about assessment between the education and clinical departments. No formal forums existed for the midwifery staff involved in assessing to raise and discuss any problems they were experiencing or for educators to explore and receive feedback on issues such as the quality with which the assessments were conducted. Because of pressures on educators and practitioners, clinical liaison relationships were reported to be poor, and hence the provision of more informal support was limited.

In this instance, as in other examples from the data, there was a need for monitoring strategies which provide supportive environments, backed up by commitment and the resources to take action. Failure to engage in monitoring activities and to act on the results maintained the status quo and meant that some poor-quality assessment practices consequent of deficits in the skills and professional development of assessors remained. At best, some average or good students may miss out on development during some practice placements, and at worst some poor students may 'progress' through assessment undetected and unassisted, with the possibility that erroneous summative assessment decisions may be made regarding their level of competence.

In general terms the task is to create an institution or a system that learns. The learning institution is one which has structures appropriate to the aim of learning from experience and capable of modifying its structures accordingly.

6.3 Learning from monitoring

The principles required for effective monitoring and development include:

- the involvement of all relevant groups
- appropriate support
- putting discussion about assessment on the agenda
- action based on discussion
- development on a national level.

The involvement of all relevant groups

The occurrence and frequency of forums for practitioners involved in assessment (e.g. assessors' meetings or end of practice placement/unit discussions) varied widely between approved institutions, as did the attendance at sessions and the quality of activities that occurred during them. Regular attendance by practitioners at discussion forums or feedback sessions was not always easy due to workplace commitments, but it was a vital contribution and feedback was obtained from those directly involved:

> *'In fact we've already changed the profile from the common foundation programme as a result of feedback from clinical staff. Certainly from the feedback we're getting back now it is clearer. I don't think it was user friendly enough and perhaps some of the aspects were a bit generalised.'*

Students were often not included in such forums about assessment experiences on practice placements. Where they were, however, good practice, difficulties and problems were discussed, and in several instances appropriate action was taken.

Appropriate support

> *'. . . we have the end-of-course feedback from the whole group on everything in general and we also have a group of service staff and educational staff chaired by the education staff who are the assessing panel and they constantly monitor the assessments . . . that is the formal mechanism, I'm not convinced that there is a great deal of what I would call individual feedback, "Do you want some help with this sister because perhaps we could help you improve on so and so".'*

> *'. . . from my own personal point of view I think the evaluation that we're doing really needs to be taken on board in more detail, and really looked at – the issues underlying some of the evaluation material that's coming up.'*
>
> *(educator)*

Many staff recognise the need for more targeted, individually tailored activity in addition to more 'formal' structures. However, being able to devote sufficient time to carrying out those activities which are the most helpful, and having the space to act on them is often difficult, given existing clinical liaison roles.

Putting discussion about assessment on the agenda

As monitoring and feedback activities compete with other activities, it is easy for them to be marginalised by other workplace demands. Whilst this is understandable in the

current climate of competing priorities, there is a need to air and discuss assessment issues that have been identified informally:

> *'I think again there have been some midwives who have informally mentioned it. You know if you get the opportunity to get a midwife to talk to you when you go, inevitably it will come into the discussion, but I think it's a bit ad hoc, rather than a formal network that is available for that. And I suppose in part that's as much to do with the teacher as well – teacher responsibility as well as midwife responsibility.'*

Action based on discussion

When assessment issues form the basis of discussion and actions are identified to improve practices, mechanisms need to be available to put these into practice. The following three issues were suggested as limitations on development.

- For a variety of reasons, it was not always possible to implement changes and development to the assessment strategy within a short space of time, and in some cases not at all. Implementing some changes which fundamentally altered the assessment system required re-validation. More minor alterations to the assessment system could often be implemented without requiring re-validation of the assessment strategy, but even then they may take a while to occur. Where immediate change is not possible, the reasons for this should be communicated to the relevant parties, so that frustration and lack of faith in a system which is perceived to be static does not occur.
- Staff noted that the pace of change must be carefully planned and monitored so that those involved are not overwhelmed by a constant round of change which may be alienating:

  > *'. . . [assessments] could be monitored a little bit to produce a higher quality and I think that's where the college needs to be working with us a little bit closer. But I'm not looking for that at the moment because I don't want to push the staff any harder. But I think it needs to be a gradual increase and pressure put on the service side to improve the quality of those assessments.'*
  >
  > *(clinical manager)*

  > *'. . . in talking about the assessment strategy one has to be very careful in bringing about change that you don't actually invalidate what went before, because that raises questions about their qualification doesn't it? So it needs very delicate handling.'*
  >
  > *(educator)*

- If action does result from monitoring activities, the manner in which this is conducted and the outcomes which result are vital. For example, sensitivity is a crucial factor when tackling issues of poor practice. The confidence of one group of students was shattered by what they felt was poor handling of a fellow student's comments. After expressing negative views about a practice placement experience with tutors in confidence (as they perceived it) at a review session, the student and her peers were upset to discover that this issue had been taken up with clinical staff without their knowledge and in a way which they felt implicated the student directly. As a result the students lacked faith in the system, believing that their experiences would not be handled sensitively and they expressed reluctance to be so open in future.

The devolution of planning and developmental activities from national to local level which has occurred in recent years has created a growing climate of competitiveness and secrecy between approved institutions. Many educators remarked upon what they perceived as a climate of less sharing.

> *'But what we need are systems in which we can share ideas and also cross-fertilise everything. And I mean colleges of nursing, to be frank, by and large are notoriously defensive about sharing anything and I think that hasn't been improved by Project 2000 . . . It hasn't been improved by the White Paper, in fact I think it will make it worse. If we're in competition with each other then we don't want to give too many of our secrets away and I think that that may make it more difficult to ensure equity and parity and all those kinds of things between the levels of qualification.'*

Considerable effort is invested in the developmental activities of approved institutions, and the reluctance to share and 'cross-fertilise' ideas if relationships are not mutually beneficial is understandable. However, in light of the learning curves currently experienced by approved institutions as they design and develop assessment strategies, there appears to be a place for greater dialogue at regional or national level, where assessment issues can be debated and ideas shared to facilitate progress.

Providing the context

A learning institution or system is one which has in place the structures and associated mechanisms and procedures which generate reflection, facilitate the sharing of ideas and experiences, and organise feedback appropriate for decision-making and for action.

The institution or system provides the context within which the student's own learning and assessment takes place. The quality of the contextual arrangements affects both the quality of the student's experience and the quality of the judgements made about the student's ability to practise. There is no short cut to quality.

THE ROLE OF DIALOGUE IN THE ASSESSMENT OF THEORY AND PRACTICE

7.1 Introduction

This chapter addresses the problem of how to assess knowledge as an aspect of competence in a way that promotes learning at the same time. It begins by examining the knowledge students learn in the classroom and explores how this experience shapes their ideas about theory in relation to learning and assessment. It then considers how private and individual knowledge can be made public through dialogue which facilitates comparison, exploration, critique and the eventual establishment of a dialogic culture. It looks finally at dialogue as a mechanism for combining learning and assessment in which theory is examined in the light of practice and practice in the light of theory.

During practice placements students often encounter attitudes, values and practices that are in contention with each other. The critical reflection which enables them to evaluate these alternative views in a principled manner is primarily developed through classroom discussion and writing. In many classrooms, however, very little attention is given to systematic discussion of the relative merits of different theories or of the values that inform them. Very few curriculum statements give any indication of a focus on dialogue about alternatives. This chapter records the types of knowledge that are being constructed in the teaching-learning interaction in classrooms, and examines some of the mechanisms which can promote movement from the collection and synthesis of beliefs, rules, procedures and knowledge, to collaborative critical reflection that can facilitate their reconstruction for improved and principled practice.

7.2 The role of dialogue in assessment

Neither 'assessment' nor 'knowledge' is a singular concept. What each means to any individual may differ markedly from what it means to someone else who has a different 'lived' experience of it. In the course of 'doing assessment' or 'doing learning', differences in an individual's perceptions of knowledge and assessment become evident. The most powerful element in the construction of each of these is dialogue, in which perceptions are focused and new understandings constructed.

Knowledge and understanding are developed at a number of different levels. At one level there is the understanding which stems from habitual doing; at another, the more holistic understanding that comes from reflection on beliefs, procedures and ideas; at yet another, the richer and more complex understanding which comes from the re-organisation of individual conceptual maps in the light of collaborative critical reflection. Through discussion an individual can move from one level to another by first identifying and internalising criteria for effective action that will improve professional practice, then making the rationales of judgement and action explicit through critical reflection. Dialogue, therefore, provides the framework within which individuals can evaluate and develop their knowledge base alongside their competence in both classroom and the clinical environments.

7.3 Constructions of knowledge

Before looking in detail at dialogue as a mechanism for learning and assessment, we must examine the knowledge with which it will be concerned. Both theory and reflection-on-action are learned predominantly in classrooms, so we will start by examining the nature of the student's encounter in these non-clinical environments.

Knowledge as 'basic' facts

In many of the classrooms observed, teachers presented lectures on physiology, sociology, psychology and other disciplines, transmitting information for students to store for later use in practice. Typically, lessons were concerned with 'text-book' information and students were encouraged to learn terms written on the board or overhead projector sheets. Students were left in no doubt about the 'official' status of the information, which was prominently linked to key 'authorities' in the field. In one classroom, for example, the Lickert Introspection Assessment Scale was introduced, attention drawn to a detailed version of it on the overhead projector, and the students encouraged to scribble furiously in an effort to get down the main categories whilst the lecturer was speaking. The net effect was to place the emphasis on the teaching rather than the learning, and to suggest that a key competence was the ability to recall what had been taught.

Most staff saw this initial transmission of basic information as an essential preliminary stage to reflective practice. Many students, however, learned from this heavy early input that theory was of little immediate relevance to practice. When more advanced knowledge was introduced later with the aim of providing a critical framework for evaluating practice, it too was treated as information to be assimilated rather than applied.

Knowledge as up-to-date information

Alongside basic theoretical information most programmes offer basic practical 'theory', which, like the abstract theory, is learned prior to practice placement. Much of this 'practical' theory, which includes information about interpersonal skills (such as communication skills), technical skills (such as lifting and artificial respiration) and care for specific conditions (such as bedsores and pain) comes directly from texts written by 'experts'. Unlike 'academic' or 'discipline' expertise, this practical expertise is perceived as potentially useful. A striking account of its use is provided by a midwifery student in her spoken account of clinical work she undertook as part of a fieldwork study:

> *'. . . foetal heart monitoring . . . during labour . . . I would come back on to the delivery suite and actually look at some . . . monitorings . . . [and] try and identify problems . . . so it was just taking theory back to practice.'*
>
> *(midwifery student)*

Interestingly, most students did not see this kind of practical knowledge as theory.

Knowledge as synthesised 'know-how'

Many students reported learning from each other's experience through post-placement 'reflection days':

> *'. . . it's through your own observations you pick things up . . . not from books because we've done very little practical [in the classroom] . . . you go on your ward placement and you come back then you know your practical theory when you come back . . . you don't learn anything practical going out, you learn when you come back.'*
>
> *(nursing student)*

There is an implicit recognition that the broader picture created when a range of experiences is shared by a group can lead to insights that go beyond the particular:

> *'. . . it was quite good because we're split sites, some are at X and we're*

here and we have . . . reflective sessions because we're usually on the same areas at the same time and we have two totally different experiences.'

(midwifery student)

The distinction here is between individual knowledge learned in a single practice placement and corporate knowledge developed through the synthesis of information from a range of placements. The central issues at stake are:

- the value of incremental (or piecemeal) knowledge *vis-à-vis* holistic (or broad picture) knowledge
- the value of a priori theory *vis-à-vis* experiential (or grounded) theory
- the value of subject knowledge *vis-à-vis* nursing knowledge.

Knowledge as a framework for analysis and critique

Although basic theory, up-to-date practical information and synthesised know-how provide the pieces for a foundation theory of nursing practice, they rarely lead to critical reflection. This does happen, however, where the curriculum has developed an attitude of enquiry in students, leading them to develop analysis as second nature:

'. . . you go out and you think "why does she wear that" you know, and you think "where does she come from?" and "what possessed her to wear" . . . sitting next to somebody and you think "oh well he's looking to go out with her and she's looking such and such" . . . she doesn't like . . . he's sitting this way . . . it becomes your whole way of thinking after a while . . . you just adjust to it . . . it just takes you over really.'

Such a curriculum encourages students to review their experience in the light of a developing theory, rather than merely to offer an 'explanation' of it, and it helps them to understand the need for analysis to be supplemented by an 'argument'. It also obliges them to ask questions about current practice in order to discover alternatives:

'. . . they want us to question things more and you do . . . I mean you really do . . . you look at alternatives.'

(nursing student)

'I know when we were on delivery suite they found it quite difficult because we were the first course through and they said they couldn't believe that we asked . . . questioning so much.'

(midwifery student)

Most programmes have a curriculum which moves students slowly through stages of information collection, application, synthesis, analysis and – in a limited number of cases – critique. In classes where critique is encouraged from the outset, however, competent students recognise complexity, seek alternatives and make a case for the decisions they take on many more occasions.

Knowledge as assessment evidence

The discussion so far has examined some of the ways students respond to informal messages about the function of theory. There were occasions, however, when lessons and tutorials were set aside for formal discussion about the type of knowledge expected in assignments. Many students who were initially anxious about their capacity to demonstrate comprehensive knowledge, became more concerned about its validity and appropriateness. In programmes where there was regular targeted feedback, students felt they had a clearer picture of how to

show their knowledge and understanding in assignments. Nevertheless, where explicit criteria differed markedly from the 'advice' implicit in the hidden curriculum, students often believed what they experienced rather than what they were told, and reverted to producing assignments characterised by 'bolted-on' (i.e. non-integrated) information offered for assessment purposes rather than because it meant something to them.

Sometimes preparation sessions themselves perpetuate a focus on basic information. In one typical class where the students met their programme co-ordinators to discuss an imminent written assignment, students asked questions – such as: 'can you just go over what we should know about body language?' – which indicated their assumption that there was a 'correct' content to be included.

Significantly, the teachers did not challenge this assumption, but 'mapped' briefly the general territories for which facts should be learned in detail. They also responded with an offer of a group tutorial on the respiratory system for those who had missed out last time or who were a bit unsure. Students learned that for assessment purposes it is better to be safe than to venture on to new ground, and that accuracy in factual recall is paramount.

Discussions often generated questions that were implicitly about the nature and range of ways in which theory could be made to relate to practice. In one preparation lesson, two students asked respectively:

> '. . . *can we focus in on just one aspect, you can't do much in just two thousand words?*'

> '. . . *can you provide a small range of examples?*'

These were really questions about the relationship between the context-specific and the generic, but they were answered as if they were procedural questions. The teachers suggested that examples had to be selected carefully to fit into the word limit of the assignment. There was no discussion about other possible criteria on which examples might be provided. No-one mentioned, for instance, the value of presenting a range of views through these examples. Indeed, it was suggested that hypothetical examples might be used to make the point, implying that the purpose of examples was to illustrate theory.

In many of the lessons observed, what was shown to count for assessment purposes was first and foremost the ability to demonstrate familiarity with theory and to make that familiarity evident to the reader. Secondly, it was the ability to show that the writer could think of some instances where the theoretical point had been demonstrated. Where assessment criteria are fully explored by students and teachers in preparation for writing, and where they match the criteria used in learning at other times, writing for assessment can become an educative activity. Where there is a mismatch it becomes a largely irrelevant time-consuming imposition which reinforces the message that theory has little to do with the 'real' world of practice.

7.4 The assessment of knowledge

Appropriate assessment formats for different types of knowledge

How theory is perceived and experienced affects the way it is assessed. A student's familiarity with up-to-date know-how and the findings of specific clinical research about physiology, drugs, physical care techniques and communication 'skills' can only be assessed as part of practice placement where it can be observed in action. The understanding they develop from exposure to de-contextualised basic information is difficult to assess during practice, but it can be assessed in subsequent discussion or writing. New knowledge from discussion about practical experience after the event can be assessed in subsequent practice. Analytical and critical

understanding which, as the research shows, are difficult to assess in the clinical environment because time for dialogue and reflection-on-action are at a premium, can be assessed in writing or through a process of critical reflection built into the heart of the curriculum. Perhaps, therefore, there should be different assessment criteria used to assess different kinds of theory.

Different forms of theory are given focus at different points during a programme, with the assessment of theory and practice together being a more important criteria in the latter part. Should assessment reflect this? Or should the criteria for differentiating analytical explanation from argument be more fully explored to encourage the earlier introduction of critical reflective practice?

Marking criteria

Students develop a keen sense of what counts as knowledge in the classroom, and acquire an unofficial set of criteria for how it will be assessed. In every institution, however, there is also a set of explicit written-down assessment criteria. The only possible way of achieving some degree of compatibility between these is through dialogue about the differences between the 'ideal', as represented by the official assessment schedule, and the 'real', as represented in the hidden curriculum of classroom interactions.

Marking schedules have the potential to influence student perceptions of knowledge. They can give credit to students for what they know about – the terms they are familiar with, the taxonomies they can repeat, the authorities and models they can quote – or for what they can do with that knowledge – their ability to see issues, to apply theories differentially in relation to contexts, and to critique practice and theory itself. They can value evidence of basic knowledge or of understanding and reflection. A survey of marking criteria used in a number of education institutions has revealed that they are intuitively divided into 'lower order' and 'higher order' categories with the higher order set of categories including the use of analysis, judgement and critique, and the lower order set focusing on knowledge-collection, synthesis and display.

Grade A

Clear evidence of wide reading and understanding supported by appropriate [correct] use of reference; clear evidence of relevant research; clear expression, debate and argument indicating some critical appraisal of facts, comparing and contrasting of issues and the relating of theory to practice where appropriate.

Grade B

Some evidence of relevant research; sound knowledge and understanding of issues being addressed; some attempt made at using knowledge to draw conclusions and explore relevant ideas, relating theory to practice where appropriate.

Grade C

Largely descriptive with little discussion and interpretation; some application of theory to practice where appropriate.

Grade D

Restricted application of knowledge to situations; superficial handling of the issues discussed; descriptive account showing little evidence of reading; no significant errors or inaccuracies which might imply dangerous practice/judgement.

Grade E

Inadequate levels of knowledge; minimal evidence of understanding; many unsupported statements; presence of errors and/or inaccuracies which may imply dangerous practice/judgement.

Figure 8: A marking schedule that values critical analysis

Figure 8 shows a marking schedule that values critical appraisal, consideration of alternatives and the application of knowledge to situations. The use of reading and reference is to be appropriate, suggesting a concern that the students' judgement should be evaluated. It also challenges the value of unsupported assertion, and insists upon the partial integration of theory and practice.

7.5 Strategies for improving the assessment of knowledge

The current situation

The classroom component of nursing and midwifery education has a potentially important role to play in refocussing student expectations about clinical competence. In particular it has the potential to enable students to become competent at using experiential and theoretical data, at doing analysis, at critiquing and at seeking alternatives, as well as to value these processes. In the research, students from some classes were more aware of the need for reflection and critique, and more used to applying them, than students from other classes. These differences appear to be influenced by:

- individual staff approaches to teaching
- discussion of assessment criteria with students
- assessment training programmes for staff
- opportunities for teacher-teacher dialogue.

Before teaching staff can help students reach a clear understanding of the criteria for assessment that will be applied to written work, they must have a degree of agreement amongst themselves. Where informal teacher discussions or more structured workshops occurred on a regular basis, analysis, argumentation and critique were stressed as assessment criteria.

Ways of moving forward

Analysis and critical reflection were most in evidence on programmes where staff had regular discussion about their own differences in perception, and about the values which inform their different judgements. Reliability was improved by strategies such as:

- double-marking followed by discussion
- sample monitoring to establish marker comparability
- marker workshops to clarify criteria
- course grading meetings to scrutinise the form of the assessment.

For strategies like these to be effective there must be accredited time provided for teachers to hold regular markers' workshops to compare their comments, discuss their differences and evaluate their criteria. In one institution, for example, it was agreed that references to 'authorities' should only be credited where the use of an authority genuinely helped the case being put, and that uncritical analysis in the final paragraph was not sufficient to gain a high mark. Dialogue between markers is the single most effective mechanism by which better teacher understanding of the criteria employed to assess student knowledge is developed. Where dialogue takes place between teachers and students as a central part of the curriculum the effect is even more marked.

7.6 The function of dialogue in the learning and assessment of reflective practice

The educative function of dialogue

All nurses and midwives reflect on what they are doing as they do it. However, this thinking-whilst-doing normally takes place privately, in the head of the individual nurse or midwife, and is situation-specific and therefore context-dependent. A competent practitioner must be able to operate across contexts and apply principles in a context-sensitive way. It is generally believed, therefore, that reflection on practice (Carr and Kemmis, 1986), where practical thinking in one situation is made explicit, built on, and used in another, should be developed through discussion. The move from novice, who assesses each clinical situation as if it were a one-off, to competent practitioner, who perceives nursing or midwifery holistically, demands dialogue before, during and after action. In this way, action and reflection impinge upon each other and over time result in changes both in the practice ('what' is done and 'how' it is done) and in the theoretical framework for that practice ('why' it is done). Dialogic conversations are mutually educative, they bring about new understandings on the part of both interlocutors.

Dialogue is an essential condition of institutional life, whether or not it is encouraged. Where it is actively encouraged, however, it promotes new forms of institutional understanding which can in turn establish a permanent dialogic culture. In such a culture, differences between understandings are acknowledged from the outset, the ethical and practical issues those differences raise are made a major focus, and the possibility of multiple voices is entertained. Dialogue focuses on the principles by which one part of the knowledge base becomes privileged over another.

The assessment function of dialogue

The great advantage of dialogue is that it facilitates assessment as part of the learning process. It not only provides an opportunity to make understanding public (and therefore available for evaluation), but also offers a chance to consider the values and theories embodied therein. In a dialogic situation, instead of simply ticking a chart to indicate what has been agreed upon, students and their assessors can indicate where there have been disagreements and doubts, offer information about their various views, and document the process by which decisions – including any decision to indicate where consensus could not be reached – were arrived at. As Rowan says:

> *'. . . the only values, the only ideas, the only concepts, the only form of existence which will be truly stable and coherent will be one in which opposition is included rather than kept out; all such notions, from the standpoint of traditional logic, will appear paradoxical and absurd.'*
>
> *(Rowan, 1981, p. 131)*

Successful assessment dialogue must be founded on a recognition that nursing and midwifery are complex practical activities informed by a multi-dimensional theory which embraces potentially competing views of the world.

Counteracting institutionalised loss of 'voice'

The culture of many healthcare organisations institutionalises disempowerment whilst paying lip-service to nursing and midwifery as activities which depend upon the quality of the carers as decision-makers. If we accept that critical dialogue and the actions which follow from it are two of the things which distinguish professional nursing/midwifery from other forms of

caring, then we must seek to institutionalise discussions where there is an opportunity for an interplay between the micro-issues of particular clients or specific caring practices, and the macro-issues of policy, resources and values. A dialogic context encourages the exploration and deconstruction of habitual practice, and this in turn results in an institutionalisation of reflective practice. In dialogue built around the notion of critique(al) reflection, both student and assessor have what Hirschman (1970) calls 'voice'; together they can determine where there are possibilities for transformative action.

Creating a dialogic culture

Whatever the culture of the clinical environment, students engage in reflection-in-action; through it they consider situation-specific real-time problems. A specifically dialogic culture encourages reflection-on-action, and even reflection-about-reflection. In such a culture, discussion occurs before, during and after an activity, as a matter of course. Participants in the dialogue begin to locate their situation-specific behaviour in a broad theoretical framework, and examine the relationship between general principles and specific actions. In discussing things which prove 'problematic', students begin to make explicit to themselves their knowledge and assumptions.

Health service institutions are essentially places where competing discourses and value-systems cohabit. By failing to generate an evidence base which allows beliefs and discourses to be critique(ally) evaluated, the current system for assessing nursing and midwifery competence fails to acknowledge this fact. Nurses and midwives constantly have to organise apparently contradictory information, analyse that information critically, make judgements on the basis of the analysis, and take appropriate action. It is essential, therefore, that the assessment of competence examines these skills (see Figure 9).

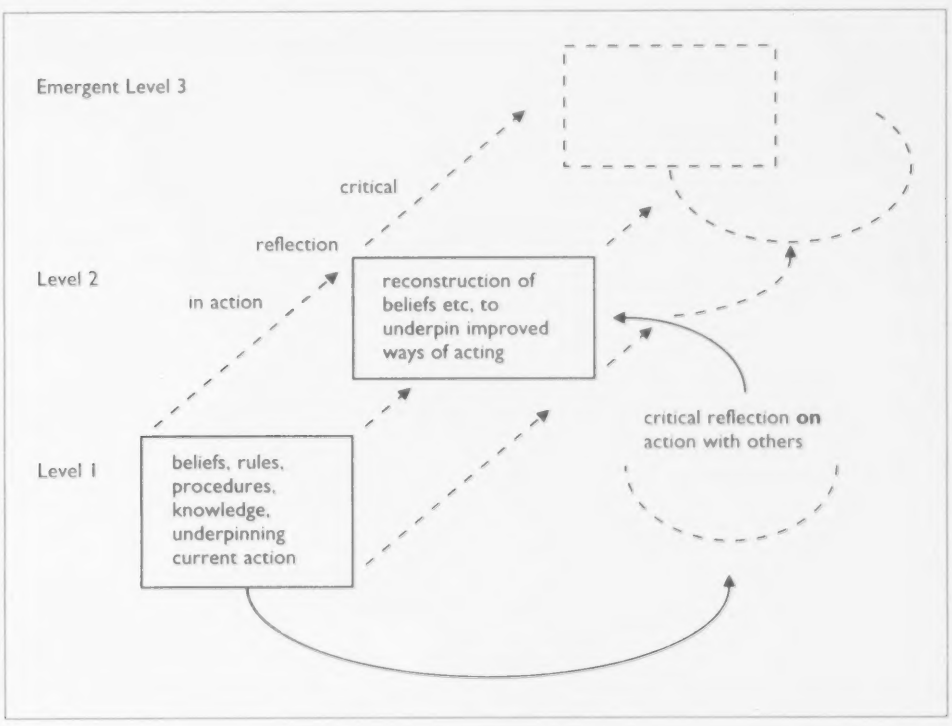


Figure 9: Towards critical reflection

7.7 Structures and mechanisms for dialogic assessment

A comprehensive, contestable evidence base

The case for building critical dialogue around the careful analysis of well-documented evidence from multiple sources is a strong one. It is essential, therefore, to find appropriate strategies for bringing dialogue from the margins to the centre of the assessment process. To be appropriate these strategies must be achievable in the multi-dimensional occupational context as it currently exists; they must also ultimately have greater benefits than costs, and must contribute to quality in nursing and midwifery in the short or medium term, as well as providing in the longer term a better qualified initial entry to the profession. The strategies which will ensure all three of these goals will be ones that enhance the analysis of evidence and the making of informed judgements which take account of the broadest possible set of relevant contextual factors.

Opportunities for dialogue between student and assessor are most likely to develop where evidence about the student's competence is contributed by more than one accredited witness. Multi-source evidence automatically invites the making of comparisons and the addressing of contrasts. The criteria for selection of one piece of evidence as opposed to another become a central issue for debate. So, too, do the potential contradictions between the various discourses that become apparent when evidence from a range of sources is juxtaposed.

In addition to a comprehensive evidence base compiled by more than one witness, it is necessary to have a framework for discussion which avoids analytical criteria that are too bland and over-general, or too specific. That framework requires student and assessor to formulate questions about theories of nursing and midwifery that can be explored further in the light of evidence from a variety of other situations and theoretical sources.

A dialogic framework for reflection-on-action

The procedures for achieving and documenting the development of the essential nursing and midwifery competence of reflection will include the following:

- the discussion of criteria used to identify skills and attitudes
- the negotiation of principles for including items in a portfolio of evidence
- the evaluation of evidence in terms of comparative comment that identifies the issues raised by differences in perspective
- the development of responses to concrete and context-related evidence in terms of a theoretical framework
- the identification of development in knowledge, attitudes, values and understanding
- the agreement of an account of the issues raised
- the agreement of an account of the development in understanding that has occurred
- the written documentation of agreed accounts.

A dialogic framework for 'critical' reflection

In critical reflective dialogue the assumptions underpinning analysis are themselves treated as open to examination. Nothing is taken for granted or treated as self-evident; everything is regarded as open to interrogation. The purpose of critique(al) dialogue is to promote a constant

interplay between theory and practice. The procedures for developing a dialogic critique of practice include the following:

- the agreement of ground rules for interrogating the taken-for-granted
- the discussion of frameworks for looking at competence in the light of practice
- the writing of suggested modifications to frameworks, with the justifications for change made explicit
- the incorporation into assessment schedules of 'why' questions that seek to discover the options considered by a student when faced with a problem in practice, and the reasons for the choice finally made
- the employment of student self-assessments which require the student to discuss particular instances of their practice in terms of general principles
- the agreement of an account of the development in understanding that has occurred
- the written documentation of agreed accounts.

A framework for continuity of dialogue across practice placements

The establishment of a mechanism for comparing and developing perceptions of competence from one practice placement to another can facilitate assessment that addresses the student's needs at an appropriate level. Where there is no dialogue between an earlier assessor and the current one, the student may be assumed to have little or no experience of doing things of which they have in fact demonstrated considerable competence in on a previous occasion. Mechanisms for ensuring that a student's competence is assessed at the appropriate level will include the following:

- time for a new assessor to read a new student's portfolio of evidence from earlier practice placements
- regular meetings between education and clinical staff for the latter to share their experiences of the assessment process
- occasional workshops for examining the nature and quality of the evidence of competence collected in different practice placement contexts
- dedicated time for teachers to explore assessment issues with clinical staff across environments.

EPILOGUE

The aim of the assessment process is not only to make judgements about the performance of students but also to sensitise the student to the work situation. Care is a specialised sphere of work. It is the professional's work to draw on past experiences in relation to projected possibilities and make judgements about how best to manipulate and transform objects in the social and physical world to create appropriate conditions of care. Formative assessment processes draw students into the ambit of the work of the professional, enabling the student both to reflect with the experienced professional at the same time as events are happening, and also afterwards to reflect on, critique and learn from what happened. This model of assessment as being intricately tied to the processes of work and education contributes to the conceptualisation of what it means to be a competent practitioner. Throughout the report the data supports a conceptualisation of competence as not a 'thing', not an 'outcome', but rather a multifaceted process. Competence, it has been argued, is an expression of work where work itself includes the whole complex of processes through which individuals learn, judge, make decisions and act to manipulate and transform the world for human purposes, then critically reflect on the results and begin again the process of work.

The institutional structures required to implement this conception of the process have been progressively explored throughout the report. Since no one institution is identical to another, no general assertion of what is required can be made. However, it is possible to contribute to the debate by making observations about structural needs. This is done in detail in the recommendations which follow this epilogue. These recommendations are underpinned by a conception of the entire process through which institutional structures, work processes and reflective practitioners are all integrated in a research-based cycle of assessment and education.

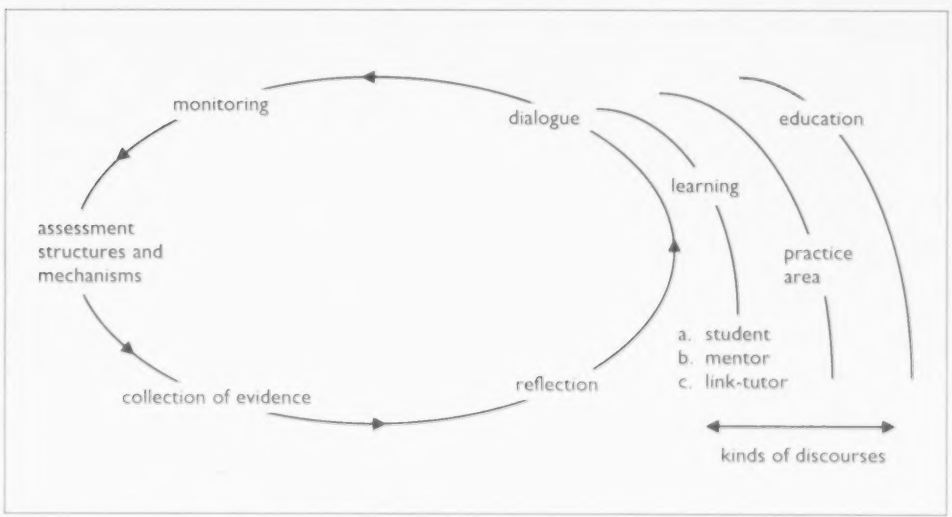


Figure 10: The integration of assessment and learning through structured dialogue

Figure 10 focuses on the cycle for the collection of assessment evidence through the structures and mechanisms established by an institution. These are then reflected upon by a) the student, b) the mentor and c) the tutor. Each interpret the evidence according to their own particular discourses – the learning discourses of the student, the practice/work discourses of the mentor, the educational discourses of the tutor. If these are not placed into dialogue then

each will take their interpretations individually and no integration will take place. If there is dialogue, then this too can feed into the monitoring processes through which the assessment structures and mechanisms can be evaluated in terms of their efficacy for forming an appropriate evidence base. And the cycle begins again.

Essential to the process is structured dialogue. At the heart of the recommendations to come from this report is the view that both dialogue and the creation of evidence for critical reflection must be structured into the system. Taking a more general interpretation of the model, it points to the research process as underlying the processes of learning, assessment and professional activity.

This is recognised in the Taskforce report on research (Department of Health, 1993) which comments that, to comply with the UKCC, professionals 'require reliable research which evaluates practices and procedures, as well as individual professional experience, if they are to fulfil their contractual responsibilities with their employing authority' (2.1.3). They considered that 'Education and training are vital to the dissemination of knowledge and the generation of critical and enquiring approaches to practice' (2.2.7).

The general aim is to refine the judgement of the knowing subject through research and education to meet the changing demands on the professions. More generally, what is required is the knowing subject as a reflective practitioner within a community of reflective practitioners each engaged in critique to improve practice. This, effectively, is a definition of research-based professional practice.

The fuller implications of this are far-reaching both for clinical and educational practice in nursing and midwifery. The recommendations that complete this report are intended to contribute to the debate on the appropriate structures, mechanisms and procedures that can be employed to fulfil the vision.

Recommendations for action to develop the assessment of competence in nursing and midwifery education, and to better enable the integrated assessment of knowledge, skills, attitudes and understanding

This report suggests recommendations for changes in the assessment of competence in nursing and midwifery education that are based directly on the research findings of the ACE project. An outline of the relevant findings is provided under each heading which is followed by a key recommendation. Below the key recommendation there is a list of contingent recommendations which offer suggestions about the structures and mechanisms by which the key recommendation may be achieved. In the spirit of the argument presented in the main research document, these contingent recommendations are presented as propositions for discussion.

The ACE research shows that policy-makers in organisations providing nursing and midwifery education interpret the original Board framework for assessment in a variety of ways. It also shows that the organisation's own guidelines and procedures are then re-interpreted by the individuals who carry out the policy. The pragmatic and cultural practices in an institution impose further constraints upon what happens. The consequence is that there is often a considerable gap between the rhetoric of documentation and policy and the reality of what happens in practice. Many of the recommendations which follow acknowledge the existing intentions but aim to suggest appropriate structures and mechanisms for closing the gap between intention and reality. Some of the recommendations add another dimension by focusing on dialogue, analysis and educative practice, and propose further procedures for its implementation.

The collection and discussion of evidence of competence

The research demonstrates that the central assessment device of student-assessor meetings (of which there are normally three) to discuss progress in the practice placement area is potentially a valuable one. It also shows, however, that where these meetings do not function as effectively as they might it is because they are hurriedly carried out, the student and the assessor discuss the student's competence primarily in terms of 'coverage', and there is limited close analysis of the evidence that demonstrates the student's competence. We recommend that to redress these shortcomings the following strategies should be instituted nationally for all practice placements.

1. **The assessment of clinical practice should require the collection of a range of forms of evidence to serve as the basis for student/assessor discussion about knowledge, skills, attitudes and understanding.**

   1.1 Protected (i.e. timetabled) time should be allocated for mid-placement discussion between student, assessor and other appropriate staff.

   1.2 During the mid-placement assessment, time should be allocated for carrying out the procedures for collecting, analysing and reflecting on evidence defined in recommendations 1.3–1.7 below.

Recommendations

The formative assessment should be used as follows:

1.3 to review the student's activity to date in terms of issues

1.4 to offer the student targeted, evidence-based feedback on how their present understanding of the issues is perceived

1.5 to outline an action plan for studying the issues in the second part of the practice placement

1.6 to discuss and agree the principles on which an action plan for student development is to be formulated[1]

1.7 to record in writing the evidence offered in discussion, the feedback advice given, the issues raised and the agreed principles for shaping the action plan.

1.8 During the final summative assessment, additional time should be allocated to carry out the procedures for reviewing current and preparing for future practice placements defined in recommendations 1.9–1.11 below.

The summative assessment should be used as follows:

1.9 to discuss the formative assessment and any subsequent evidence relating to it explicitly in terms of knowledge, skills, attitudes and understanding

1.10 to record the issues from the discussion in an agreed format which will provide the focus for later study

1.11 to construct a portfolio of evidence from the practice placement as a whole which will be available to assessors for subsequent placements.

Continuity and progression in the development and assessment of competence

The research indicates that assessors often experience difficulty in ensuring that students are advised and assessed at a level commensurate with the student's practical placement history and level of theoretical understanding. One of the reasons for this is the prevalence of short practice placements which make it difficult for assessors:

- to gather evidence of complex competencies
- to carry out diagnostic assessment
- to ensure student progress with respect to identified needs.

A further reason is that many assessors operate within a narrow theoretical framework founded primarily on their current clinical context and leaving out of account the need for development across contexts. Most assessors have had only limited training for their role and are unused to discussion about the relationship between the principles of practice they apply in their own clinical area and the operation of those principles elsewhere. Indeed, students are often left to construct their own continuity between practice placements, a situation which places a considerable burden of responsibility on them. To ensure continuity and progression of student learning, assessors must be able to carry out appropriate analysis of student competence in context and be able to comment on the issues raised with reference to the wider context of nursing/midwifery. In the light of this we recommend the following.

[1] Examples of such principles include: (a) a principle about the distribution of responsibility in collecting evidence for assessment, (b) a principle about which aspects of practice and learning are to be prioritised, and (c) a principle about how decisions about priorities are to be decided.

2. There should be a clear procedural framework for ensuring that assessment provides continuity of reflective practice based on the collection of evidence, the carrying out of informed analysis and the construction of a theoretically informed action plan.

2.1 Assessors should indicate in documentation and discussion the level at which they are expecting students to address knowledge issues.

2.2 Assessors should gather and record evidence of development in the level of a student's competencies between the outset of a practice placement and its conclusion.

2.3 Practice placements should be long enough to enable evidence of overall progress to be reliable and progress in particular areas of competence to be differentiated according to level.[2]

2.4 Time should be provided at the beginning of a practice placement, and at weekly intervals thereafter, for at least two people to study the student's portfolio of evidence and discuss it together.

2.5 There should always be available to the student a person other than the main assessor who is familiar with their portfolio and able to discuss progress with them on the basis of the evidence in it.

2.6 Practice placements should be long enough to enable the collection of multiple sources of evidence and to facilitate fair judgements.

2.7 Assessment documentation included in a student's portfolio of evidence of knowledge, skills, attitudes and understanding should be made available to an assessor who is about to receive that student.

2.8 There should be increased opportunities for assessors to meet together to discuss continuity, with particular reference to the notion of levels of competence and the criteria that attach to them.

The professional development of assessors

It is apparent from the research that while most clinical staff are comfortable discussing craft knowledge with students, many feel insufficiently prepared to carry out the critical analysis necessary for helping students focus on particular strengths and weaknesses; consequently they lack the confidence to formulate a set of individual targets for a student to meet. The data also reveal a wide range of practices with respect to liaison between staff in the clinical areas and those in the approved education institution, and indicate a dissatisfaction on both sides with the quality of such liaison. To be able to assess students' competence on the basis of collection, analysis and reflection on multiple sources of evidence, in a manner that ensures the development of contextualised theory and clinical competence, all assessors must themselves have an appropriate level of understanding of both theory and practice. The following recommendations address these needs.

3. The preparation of clinical area assessors should develop assessors' competence in collecting evidence, analysing data and developing frameworks for discussion.

3.1 Assessor preparation should include familiarisation with 'frameworks for looking at practice'.

[2] This is unlikely to be achieved in a practice placement that is shorter than four weeks. Several of the institutions visited were already successfully operating with practice placements of four weeks or more. Several of the others were reviewing their placements in the light of difficulties caused because of the brevity of some of them.

3.2 Assessor preparation should include extensive discussion about frameworks which offer a range of alternative perspectives, and should provide experience of handling the arguments and issues involved.

3.3 Assessor preparation should include guidance on the collection of evidence.

3.4 Assessor preparation should include a focus on the identification of issues which affect the construction of an action plan for student development in the clinical area.

3.5 Assessor preparation should explore ways of ensuring that students' previous experience and the level of their theoretical knowledge are both taken into account in assessing their competence.

3.6 Assessor preparation should include guidance on the development of a critique of contextualised practice.

3.7 The role of link teachers should formally include fully negotiated responsibilities for ongoing liaison with, and support and development for, clinical assessors.

Promoting inter-assessor and student/assessor dialogue

The research shows that assessors' perceptions of competence are shaped by the clinical context in which they work, by their understanding of the relationship between that context and nursing theory, and by their experience of working with students at differentiated levels of competence. It also shows that where individual criteria for judgements are the subject of discussion and dialogue between groups of assessors, common understanding increases. There is no evidence, however, that this greater common understanding leads to a single 'objective' view; rather, it helps to make clearer the basis for a range of subjectivities and thus to encourage debate about theory in practice. The following recommendations suggest how dialogue might be promoted.

4. To ensure assessment which looks at theory and practice at one and the same time, mechanisms should be introduced to facilitate regular dialogue between clinical assessors, and between clinical assessors and their approved education institution colleagues.

4.1 Each approved education institution should institute regular forums for clinical and education staff to:

- promote shared understandings of the assessment process in that institution
- discuss the nature and quality of evidence on which judgements will be made
- identify areas of strength and weakness in current assessment practice.

4.2 In each practice placement area, the assessor(s) in consultation with the student should compile a portfolio of evidence of the student's knowledge, skills, attitudes and understanding, and should identify in writing issues to be explored further in discussion.

4.3 Discussion and documentation for both formative and summative assessments should include evidence from more than one source. The

evidence should be compared, differences noted and an account given of the analysis of those differences.

4.4 Evidence for assessment in the clinical area should be supplied by at least two assessors who would sign the assessment documentation after discussion between themselves and the student concerned. The two assessors may:

- both be practice placement area staff
- be an assessor from the practice placement area and a link teacher from the approved education institution
- be an assessor from the practice placement area and a person with a lecturer-practitioner role which includes assessment.

4.5 It is possible that dialogue between clinical practitioners and educators may increase naturally as a consequence of the Board directive that 0.2 WTE of education staff time be spent in the clinical area. We would strongly recommend that assessment be a declared orientation for all staff for a specified percentage of this time.

4.6 Where it is not already the case, link teachers should ensure that their liaison activity includes discussion with clinical staff about the relationship between theory and practice, offering papers where appropriate.

Assessment document

The research data reveal that clinical practice assessment documents take a wide variety of forms. These range from tick-charts (with minimal space for comments) that indicate behaviour observed and skills achieved, through schedules which embody lists of criteria that indicate generic competencies and include generalised statements that many assessors find 'too vague', to diaries or learning portfolios in which there are records of experience gained, evidence of the learning which has taken place and reflective discussions of the theoretical issues raised. The data also suggest that discussion between assessor(s) and student about theoretical issues arising from practice is most likely to occur where documentation provides evidence which can form the focus of a dialogue. The following recommendations suggest how assessment documents might be structured to promote such discussion.

5. Assessment documentation should be broadened to include evidence contributed by more than one accredited witness and used as the basis of dialogue about knowledge, skills, attitudes and understanding.

5.1 Assessment documents should include an indication of the areas of competence undertaken by a student and a criterion-referenced account of the quality of the student's skills and attitudes in relation to those competencies.

5.2 Assessment documents should include details of the issues raised in discussions between student and assessor(s).

5.3 Assessment documents should either provide full and sufficient space for the proper documentation of evidence from several sources, or they should clearly indicate in the instructions to assessors that they are to be compiled and read in conjunction with an accompanying portfolio.

5.4 Assessment documents should include more than one source of evidence about the matters in 5.1 and 5.2.

5.5 Assessment documents should include details of the action plan devised between assessor(s) and student during the mid-placement formative assessment.

5.6 Where assessment schedules contain categorical lists these should include categories that reflect situationally grounded theory.

5.7 A high percentage of assessment documentation should employ a process model of professional development in which the assessment activity itself promotes learning; the formative function should be central.

Regulating the effectiveness of early detection of 'cause for concern'

Somewhat paradoxically, the research shows that not only do many nurses and midwives find their current assessment schedules less than helpful as a framework for analysing students' ability to see the particular in relation to a holistic context, but also that they find them unhelpful as a way of providing a mechanism for failing 'poor' students. The way that documents are structured, and more particularly the way they are used, often means that failure is identified on the basis of the authority of the accredited witness (i.e. the clinical assessor who signs the assessment schedule), rather than the basis of carefully documented evidence from a range of sources. There were a number of clinical practitioners who were convinced at an intuitive level that the student they were assessing would make a poor nurse, but were nevertheless hesitant about signing the student into fail status. Some assessors expressed concern about their own ability to make that final decision and showed a perennial optimism about their ability to help the student improve.[3] The problem, then, is not related to the absence of 'failure' mechanisms but to the lack of appropriate monitoring of the use of them. The following recommendations address the points raised by 'failure to fail'.

6. Every institution should review the operational effectiveness of its mechanisms for early identification of students presenting cause for concern, ensuring that the procedures for evidence collection and case discussion are adequately regulated.

6.1 The use of the 'cause for concern' section of assessment documents should be regularly monitored to ensure that concern is recorded at an early stage, and certainly no later than the point at which formative mid-placement assessment takes place.

6.2 In each approved educational institution a named person with an assessment quality assurance role (see recommendations 10.4–10.8) should be responsible for ensuring that each practice placement area is aware that documented 'cause for concern' is to be delivered by an agreed time, and for sending a reminder no later than the point at which formative mid-placement assessment takes place.

6.3 On receiving notice of 'cause for concern', the assessment quality assurance officer should initiate a meeting between the assessors and the student to consider the evidence which has led to concern, and to arrange for the student to be provided with a targeted action plan.

[3] There are a number of additional reasons why assessors feel unable to take the decision to fail students, including the feeling many of them have that they are ill-prepared. Many of the recommendations suggested in other sections will help to redress these other causes of failure to fail.

6.4 The assessment quality assurance officer should not arbitrate on the fairness of the assessment at this stage, but should arrange for the student to be re-assessed within two weeks.[4]

6.5 The re-assessment should examine the strategies the student has used to improve their understanding, the quality of their reflection on the issues which the action plan was introduced to examine, and the way that they have carried out any programme of practical activity.

6.6 Details of the 'cause for concern' together with accounts from the assessors and the student of the action taken should be available to any future assessors.

The use of assessment documents to promote analytical reflection

It is clear that documentation which requires discussion between assessors on the one hand, and between the assessor(s) and student on the other, is most likely to promote the contextualisation of practice within a theoretical context and to promote understanding of site-particular issues in relation to the wider institutional, professional and educational context. It is also clear that structures to support dialogue facilitate integration between theory and practice. The following recommendations indicate some of the ways that assessment documents might be used to increase dialogue.

7. Documents should require written accounts of analytical reflection on the relationship between particular clinical events and general nursing or midwifery principles.

7.1 Documentation should be used to support situational analysis.

7.2 All the issues discussed between assessors and students during a practice placement should be recorded in assessment documents and should be the focus of a mid-placement overview of the theoretical issues raised during the practice placement to date, together with the possible implications for practice.

7.3 Accounts of discussions held during one practice placement should be available in written form to the assessors for subsequent placements.

7.4 Assessors for a practice placement should ensure that they discuss with the student at the earliest possible opportunity the account of issues raised on a previous assessment, with a view to setting a programme for the current practice placement which will further develop that student's knowledge and understanding.

The integration of theory and practice with reference to knowledge, skills, attitudes and understanding

The research provides evidence that theory is more often assessed separately from practice than at the same time as practice. It does show, however, that there are occasions when theory drawing directly on practice is assessed in the classroom. Typically, students may complete a neighbourhood profile which may include an account of practical activity they themselves have undertaken in the community, the context in which it occurred and the theoretical framework within which the study was constructed. Additionally, immediately after a practice placement block they may discuss the theoretical

[4] Notwithstanding the considerable difficulty likely to be experienced in finding an additional appropriate person in many clinical areas, it would be sensible wherever possible to involve a third, independent assessor in the re-assessment. The research shows that in clinical areas where there are several appropriately qualified assessors there is considerable advantage to the student in being seen by as many of them as possible.

issues that have emerged from their practice. More frequently, however, theory is perceived as a priori knowledge which has to be drawn upon or 'applied' in practice. To promote the bringing together of theory and practice in a way that fosters genuine integration rather than pragmatic 'bridging', and at the same time permits appropriate assessment of both components of the whole, we recommend the following.

8. Summative assessment should take account of multiple sources of evidence of knowledge, skills, attitudes and understanding.

8.1 Assessment documentation should include evidence of skills demonstrated, collected in a form which makes it possible to identify the range and type of context in which the skill has been used, and the range of different assessors who have seen it used.

8.2 Assessment documentation should enable students to provide evidence of practical and theoretical knowledge and to demonstrate that they are able to formulate theory through reflection on practice.

8.3 There should be a range of documents from which evidence is taken to determine the quality of a student's understanding and the application of that understanding to the achievement of competence. Such documents would require the student to take a reflective stance.

8.4 All the documents examining a student's practice and the theoretical context in which it has been considered, should contribute to a portfolio to be assessed as an entity for evidence of the extent to which the student has indeed integrated theory and practice.[5]

8.5 A portfolio should include several of the following items which bring together theory and practice, and provide evidence of student knowledge, attitudes and understanding:

- case studies of a project undertaken[6]
- accounts of a practical/professional problem identified and explored by the student
- student diaries (or significant extracts and stories from these) constructed during practice placement and open to inspection and comment
- learning contracts in which there are:
  - records of what has been identified from practice as needing to be explored within a theoretical framework
  - discussions of the issues raised
  - references to the reading drawn on.

8.6 The portfolio of evidence should be used to determine the student's ability to examine critically the particular and situation-specific in terms of the general context of nursing and midwifery.

Assessment of theory and practice through written coursework

The project's research in classrooms indicates that more opportunities are created for nurse and midwife teachers to meet together to agree their assessment criteria than for clinical practitioners to do so. This is partly because of the teachers' very different work pattern, and partly because of the fact that they are obliged to operate within a set

[5] See Evans, 1990, p. 51 for an outline of the advantages of a portfolio of evidence for the assessment of the competence of social work students.

[6] The term 'case study' is used here to refer to the study of an instance (using observation, collection of evidence, analysis, reflection and construction of an action plan for further exploration) which is commonly adopted as a methodology for Action Research. It does not refer to the taking of a 'case' in the more usual nursing/midwifery sense.

of procedures for the assessment of written work which have developed out of a long tradition of such assessment. Although there were disagreements between assessors about the precise level at which a piece of work had been executed and therefore the mark it should be given, disputes were resolved by dialogue between assessors who often met together as a course team. In some institutions there were 'marking workshops' where assessors took and marked specimen scripts and discussed their criteria.

Assessors experienced greatest difficulty in evaluating new forms of coursework such as projects, often varying considerably in the marks they allocated. In particular they sometimes experienced difficulty because the student had supplied an inadequate evidence base. In some instances problems arose where there was a focus on taxonomies as frameworks for understanding, and where those taxonomies were treated as unproblematic. The fact that theory was often not 'problematised' led in some cases to students perceiving it as something to apply uncritically to practice, rather than something to be reflected on in the light of practice. Where the quality of teacher contact with clinical areas was good, there was increased awareness on both sides of the fit between theory and particular contextualised occurrences. There were, however, few instances of the generation of theory directly out of practice, or of the planning and implementation of a piece of small-scale research into nursing or midwifery practice *per se*.[1] The following recommendations build on the strengths of assessment in the approved education institution and suggest ways that it might be further strengthened.

9. Assessment of written coursework should ensure a focus on the development of a coherent and explicit theory of nursing/midwifery which takes account of the complexity of practice and encourages the development of critique of both practice and theory.

9.1 A dossier of 'moves towards the formulation of a nursing/midwifery theory' should be compiled for each student. This dossier should be used to provide evidence of an individual student's development of a theory of nursing/midwifery practice, and should be available for formative and summative assessment.

9.2 A dossier should include several of the following items which bring together theory and practice, and also provide evidence of student knowledge, attitudes and understanding:

- reports on a student's area of interest in post-placement discussions in the classroom
- issue papers presented to the class for discussion
- issue-based compilations of evidence from a student's portfolio
- reports on post-placement classroom simulations of dilemmas experienced in practice.

9.3 Assessment criteria for written coursework should be made explicit at the outset of each course and students offered an opportunity to evaluate the criteria in the light of their practical experience.

9.4 Coursework which involves small-scale research into practice should be encouraged, and the way in which the criteria for assessment differ from library-based assignments should be made explicit.

[1] An interesting exception were the community studies which was undertaken in several institutions. These sometimes involved a small piece of research which necessitated observing, analysing, and commenting on the practice of other (i.e. non-nursing/midwifery) workers in the community. The value given to such studies by some institutions contrasts strongly with that given in others where placements in the non-healthcare sector were perceived as peripheral.

9.5 Wherever appropriate, clinical assessors should be invited to read and comment on assignments completed by students who have drawn on data from their clinical context.[8]

9.6 Coursework should encourage the comparison of theories and the development of a critique where appropriate.

9.7 The measures recommended from the perspective of clinical assessment for ensuring liaison and dialogue between assessors in the practice placement area and teachers who are also assessors, should be reciprocally applied from the perspective of those involved in coursework assessment.[9]

Quality assurance in assessment

Perhaps the most significant factor affecting the effectiveness of assessment of both theory and practice is the extent to which assessors apply the principles and procedures set out in their institution's validation documents. All the validation documents we studied espoused the rhetoric of reflective practice in their philosophy section. The section on assessment in the same documents usually had clear statements that formative assessment was to take place regularly and was to involve discussion between assessors and students. The documents also set out a number of structures through which formative assessment was to take place. In the context of the classroom it was, in most cases, to be dealt with through individual tutorial and post-placement feedback. In the clinical context it was invariably to be tackled through three assessment-schedule-completion events involving both student and assessor. Many clinical practitioners were constrained in the way they assessed students by the fact that they had intensely busy schedules, shift and off-duty patterns of work that were incompatible with the students', and insufficient preparation for carrying out effective analysis and discussion. Many lecturers were constrained by their heavy face-to-face teaching loads, by the fact that they were teaching and carrying out assessment across a wide range of programmes, and by the limited opportunity they had for visiting students in the practice placement area. The consequence was that there were many occasions when assessment was hurried and feedback given without explicit discussion of the evidential and value bases that informed the assessor's judgements.

Given that there is also a natural tendency for institutions providing a service to be responsive to immediate demands and downgrade time for planning and reflection, it is clear that there is a need for a further set of mechanisms to assure the effectiveness of formative assessment. The rigorous application of assessment quality assurance mechanisms may have some small additional initial cost implications; because the form of assessment recommended throughout is a constantly developing mutually educative one, however, that initial investment of time by practitioners will be repaid from savings achieved later as they understand the competence and assessment issues better. The following recommendations offer a way forward.

10. Every institution should be required to apply rigorously the Board's requirement for approved institutions to 'monitor, review, and evaluate the progress, development, and effectiveness of all aspects of the assessment process' in terms of the structures, roles and mechanisms employed for carrying out continuous assessment.

[8] Another advantage is that it may involve the student in 'clearing the data', i.e. checking their account with that of participating practitioners. This may not lead necessarily to an agreed account, but it will help the student to understand the need for recording any differences of perception.

[9] Many of the recommendations for assessment in the practice placement area apply equally to assessment in the classroom. Unless it is evident that they should not be applied to coursework assessment, it should be assumed that the suggestions apply within the education institution too.

10.1 A designated member of the clinical staff in each practice placement area should be responsible for carrying out an annual review of the professional development needs of staff involved in assessment.

10.2 A designated team of both clinical staff and education staff should be responsible for carrying out an annual review of the quality of evidence offered in assessment documents.

10.3 There should be light sampling monitoring of mid-placement discussions to ensure that they are happening at the appropriate moment during a practice placement, that they are of the duration necessary to permit reasonable discussion, that discussion is satisfactorily recorded and that practical competence is being assessed in relation to a theoretical framework.

10.4 Where not already in place, an assessment quality assurance role should be created in each approved education institution. The person appointed to this role should be known as the Assessment Quality Assurance (AQA) Officer.

10.5 The responsibilities of the AQA Officer should include the following:

- monitoring of mid-placement assessments
- receiving representations from students who believe they have a cause for complaint with respect to the time allocated to them for discussion of their knowledge, skills, attitudes and understanding.
- co-ordinating liaison between practice placement areas
- promoting continuity between assessment 'centres' through the development of shared understanding of the assessment process as a whole
- ensuring the development of assessment that brings together the clinical and the educational
- ensuring the provision of assessor forums and workshops.

10.6 The AQA Officer should be allocated time and resources to ensure planning and development.

10.7 The AQA Officer should have an ex-officio role on all Examination Boards.

10.8 There should be national and/or regional Board-approved programmes in the philosophy and practice of assessment in the workplace as it applies to nursing and midwifery. These programmes should deal with assessment and learning at a level beyond the current 997/998 courses; they should be offered to Assessment Quality Assurance Officers and the education officers of the Board in the first instance.

Research and development

The ACE project research shows that the focus in nursing and midwifery education on 'research awareness' has led many clinical practitioners and educators to conceive of research-led nursing and midwifery primarily in terms of the application to practice of findings that exist 'out there' in research papers or books. It is clear that there

is a need for nurses, midwives and educators to 'own' research for themselves through participation in forms of research which focus on practice from the perspective of the practitioner. It is also clear from the project data that there is a need to develop programmes that consider the findings of mainstream assessment research in the context of nursing and midwifery. The following recommendations suggest ways in which the research focus may be extended.

11. The current nursing and midwifery focus on research as 'research awareness' should be extended to include a focus on research process, particularly as that process applies to practice at local level and policy at regional and national levels.

11.1 There should be a concerted push to induct nurses, midwives and educators into the processes through which they can examine their own practice and become familiar with collection, analysis and reflection upon evidence. The focus should be on the development of research programmes which can be undertaken in the workplace as an aspect of quality assurance, and not upon the de-contextualised transmission of research techniques.[10]

11.2 Approved education institutions should be encouraged to seek research funding to look specifically at the operational effectiveness of their current assessment policies.

11.3 Approved education institutions should be encouraged to seek research funding to look specifically at the effectiveness of assessor preparation.

11.4 Future innovations in nursing or midwifery education should be piloted and thoroughly researched before the innovation is adopted on a national scale, with a view to establishing the most appropriate strategies for assessing any new competence involved. Wherever possible that research should involve some groundwork research by a number of individuals from innovating institutions.[11]

[10] cf. Department of Health, 1993.

[11] This was, of course, the pattern with several of the Project 2000 Demonstration Districts. In that case, because the research was not completed before the innovation was adopted on a wider scale, many programmes that were established subsequently were themselves, in all but name, pilot studies. This was most true with respect to assessment.

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Mechanisms and procedures for collecting evidence

In order to provide adequate evidence for the purposes of assessing competence as an integral part of an educative activity, texts must be open to independent re-examination, must make possible the monitoring of the assessment processes, and must provide a form of quality assurance. From our examination of the range of assessment texts in operation, this does not always happen.

Continuous assessment in practice placement areas requires a complex evidence base which reflects the realities of practical experience. It is the contention of this project that the evidence base provided by assessment documentation is frequently not adequate for these purposes.

Listed below is the range of mechanisms and procedures for collecting evidence found during the survey.

Pre-assessment

Informational mechanisms

These include:

- the provision of handbooks
- briefing meetings to ensure students and staff are apprised of role definitions of:
  - assessors
  - mentors
  - link tutors
  - other staff in the practice placement area
  - students
- briefing meetings to ensure students and staff understand:
  - the purposes of the practice placement
  - the purposes of and procedures necessary for the assessment of practice placement experiences and activities.

Professional development and student preparation mechanisms

These ensure that staff and students are competent in techniques of:

- interviewing each other to identify agendas of needs and interests
- situational analysis to make explicit:
  - the wider context of social, political, economic conditions affecting the clinical area
  - the professional context
  - the structures, principles, and procedures underpinning practice in the clinical area
  - the particular circumstances of the situation
  - the influences on decision-making
  - the constraints on action.

These encourage:

- reflection upon practice to make explicit and/or clarify:
  - staff expertise
  - comparable and contrasting cases/events that have influenced decision-making
  - student understandings/misconceptions, etc.
- discussions with a range of staff and students to:
  - share experience
  - seek to establish a consensus on what are appropriate values, ways of behaving, etc.

During assessment

Formative mechanisms to develop:

- diagnostic interviewing with mentor/assessor/link tutor
- participation in discussion with care teams
- the provision of accounts of practice, e.g. giving a running commentary during practice; making explicit internal thought processes; writing up accounts of practice for later discussion.

Summative mechanisms to ensure:

- triangulation of opinions between: assessor, other mentors, colleagues who have worked with the student, the link tutor, the student, other students
- completion of formal assessment documents.

Post assessment

Monitoring and quality assurance structures to ensure:

- role holders are appropriately qualified and experienced
- roles and procedures are actually carried out
- judgements are backed with appropriate evidence
- judgements are consistent
- assessment structures, mechanisms and procedures are consistent with rationales
- appeals procedures are available.

RESEARCHING PROFESSIONAL EDUCATION

A series from the English National Board for Nursing, Midwifery and Health Visiting

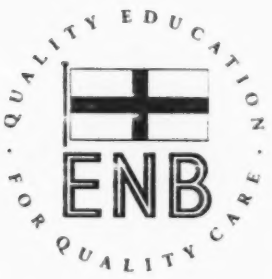
Education, Dialogue and Assessment: creating partnership for improving practice

Terry Phillips
Helen Bedford
Jill Robinson
John Schostak

This is the first report in a new series to be published by the English National Board for Nursing, Midwifery and Health Visiting.

'Education, Dialogue and Assessment: creating partnership for improving practice' is based on: Assessing Competencies in Nursing and Midwifery Education (the ACE Report) a major project commissioned by the English National Board.

This report has been written to make the results and implications of Board commissioned research readily available to policy makers, managers, practitioners, researchers and educators. The Board's intention is to enable these key stakeholders to have access to important findings from which to plan and implement developments in nursing, midwifery and health visiting education.



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